MULTIPLE AND INDIVIDUAL THERAPY: A COMPARATIVE STUDY OF CLIENT OUTCOME, ATTITUDES, AND DISCUSSION IN TWO TREATMENT MODALITIES

By

CHARLES ALAN REINER

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DEDICATION

To Gail, who continued to love and to listen, and to Alysia, who kept on loving, though at times I couldn't listen.

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PREFACE

This dissertation, which is primarily concerned with the client variables related to multiple and individual therapy, is part of a joint research project that was conducted with Sharon Kosch-Graham. Dr. Graham's dissertation, which was completed in December of 1972, concentrated on therapist variables related to multiple and individual therapy.

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Abstract of Dissertation Presented to the Graduate Council of the University of Florida in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

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By

Charles Alan Reiner

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Chairman: Dr. Harry A. Grater, Jr.
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In this project, clients in the treatment modalities of multiple and individual therapy were compared on three major dimensions. The areas of comparison were: (1) client therapeutic outcome, (2) the attitudes, feelings, and behavior of clients toward their therapist(s) and the therapy sessions themselves, and (3) client discussion.

Various psychological instruments were utilized in making the above comparisons. The instruments used were: (1) Shostrom's Personal Orientation Inventory (POI), (2) a modified form of the Klavetter and Mogar Self-Actualization Scale (SAS), (3) the Problems List (Reiner and Kosch-Graham), (4) a revised form of the Orlinsky and Howard Therapy Session Report (TSR), and (5) Carkhuff's scale of Helpee

Self-Exploration. The first three scales were administered to all clients pre- and posttherapy. The TSR was administered to all clients after the first and last sessions of therapy. The first and last therapy sessions of all clients were also rated by trained judges on the scale of Helpee Self-Exploration. The duration of therapy (number of sessions until termination) was also measured.

Twenty-four clients between the ages of 18 and 23 participated in this study. The clients were all female, unmarried, college students with presenting problems of an interpersonal nature. Clients were randomly assigned to either the individual or multiple therapy conditions. In the multiple therapy condition, the clients were simultaneously treated by a male and a female therapist.

Six experienced therapists (three males and three females) and six relatively less experienced therapists (three males and three females) took part in the study. Each therapist treated one client in individual therapy. The therapists were also broken down into six teams composed of a male and a female therapist with approximately the same amount of prior therapy experience. Each of these teams treated two clients.

There was no support for all hypotheses that predicted a more favorable therapeutic outcome for multiple as compared to individual therapy clients. Thus, there were no significant differences between the two treatment groups on two measures of self-actualization (POI and SAS). The two

groups also did not significantly differ on the dimension of duration of therapy until termination. Results from the Problems List and a TSR scale measuring emotional and psychological well-being indicated that clients in individual therapy had more favorable therapeutic outcomes than clients in multiple therapy.

Further analyzation of data from the TSR revealed that for the most part, there was no support for the hypotheses that predicted that clients in multiple therapy, as compared to clients in individual therapy, would demonstrate more positive and negative attitudes, feelings, and behavior with regard to their therapist(s) or to the therapy sessions themselves. The one exception was the finding that multiple therapy clients felt that their therapists were more negative or critical toward them.

Finally, there was no support for the hypotheses that predicted that client discussion in multiple therapy would be different than client discussion in individual therapy. Thus, there were no significant differences between the two groups on the dimension of client self-exploration. Results from the TSR also showed that the treatment condition a client was in did not significantly affect the number of interpersonal topics discussed nor the amount of discussion concerning male-female roles, or feelings and attitudes toward the therapist(s).

The findings of the present study do not support the various claims found in the literature for the greater

efficacy of multiple therapy. These results also do not support certain observations found in the literature concerning client attitudes and discussion while in multiple therapy. Possible explanations and implications of the results of this study were presented. Areas for future research were also suggested.

INTRODUCTION

Definitions

In any survey of the research concerned with a specific technique of psychotherapy, the literature's and the investigator's definition(s) of the technique are quite important. For without clear and agreed upon definitions, any attempt at objective evaluation is almost impossible. Definitions are especially important in the field of multiple therapy, since many researchers use the term multiple therapy to refer to quite different entities, while other investigators use different terms other than the words multiple therapy, which are then all defined similarly. This will become clearer as some of these definitions are presented.

Rudolf Dreikurs (1950), in defining the technique of multiple therapy states that: "All forms of psychotherapy where several therapists treat a single patient may be considered to be 'multiple therapy'" (p. 788). Another definition, which is perhaps more experiential in nature, is given by Treppa (1971): "Multiple therapy refers to the use of two therapists who are involved intimately, affectively, and spontaneously with each other and their patient(s)" (p. 452). Mullan and Sanguiliano (1964) give a slightly different

definition of this technique with regard to the number of different types of patient groups that can be treated with multiple therapy. These researchers define the procedure of multiple therapy as the "...simultaneous treatment by two therapists of individual patients, groups of patients, and family groups" (p. 551). These same authors also consider multiple therapy to be transactional, non-teleological, phenomenological, and intimate.

There are also other terms (besides the words multiple therapy) in the literature that have been used to describe a treatment situation which employs two or more therapists engaged in psychotherapy with one or more patients. Greenback (1964) uses the term dual therapy, while Lott (1952) presents the term three-cornered process to describe the above situation. Other expressions such as co-therapy, role-divided therapy, joint interview, co-operative psychotherapy, and dual-leadership have also been used with reference to this treatment situation (Spitz & Kopp, 1963).

After evaluating the above definitions it was decided that Mullan and Sanguiliano's (1964) definition ("...simultaneous treatment by two therapists of individual patients, groups of patients, and family groups") would, for the most part, be implied when the expression multiple therapy is employed in this chapter and elsewhere. One major exception to this will be in those cases where the term multiple therapy is used to describe the research done by the present author. In such instances, multiple therapy will

assume the definition of a psychotherapeutic situation in which a male and female therapist are involved in the treatment of an individual patient.

Early History

Although many consider the use of multiple therapy to be a fairly recent psychotherapeutic innovation, its actual inception dates back to the work of Alfred Adler (1930) and his colleagues at the Vienna Child Guidance Clinics in the 1920's. In these clinics, there were occasions when a parent and child would be seen jointly by a psychiatrist and a second therapist (usually a social worker or a teacher). When there was an occurrence of emotional blocking or resistance on the part of the child, Adler implemented the practice of a discussion by the therapists of the child's problem while the child was present in the room. Adler found that this practice had quite a favorable therapeutic effect on the child. In discussing this technique, Adler (1930) hypothesized that its effectiveness was due to the fact that the child was "...surrounded with people who take a great interest in his fate and difficulties, without looking down upon him and without forcing this help upon him" (p. 23).

Another influential figure in the early history of multiple therapy was G. H. Reeve. Starting in the year 1933, Reeve (1939) began working in the field of multiple

therapy. Reeve's contribution to the field was his implementation of a technique called the "joint interview," where a psychiatrist and a social worker would simultaneously treat one patient. This technique had originally been discussed at the 1933 National Conference of Social Workers as a possible method of education in the training of psychiatric social workers. Although Reeve acknowledged the technique's training value, his primary interest was in the psychotherapeutic implications of the "joint interview." Reeve and his co-workers found that the use of this technique enabled a patient to "evaluate his problem in relationship to an artificial group--a group in which the prime concern is that of assisting him to utilize his environment as it exists, for greater satisfaction and less discomfort" (1939, p. 747). Reeve believed that this new method of treatment also differed from traditional individual therapy, in that "there is a wider opportunity for identification and, therapeutically, a parental situation is set up insofar as the social worker and the psychiatrist may be identified as such" (p. 747). This latter finding was probably the first published statement that even vaguely implied a transferential model to explain the effectiveness of multiple therapy. This model will be discussed at greater length in a later section of this chapter.

Probably one of the first researchers to be primarily concerned with the training possibilities of the multiple therapy technique was Hadden (1947). Hadden found that the

inclusion of a senior medical student as a co-therapist in his outpatient therapy groups had a beneficial effect on the training of these students. This was probably due to the fact that the students could have actual experience under the supervision of a more experienced co-therapist, who had direct knowledge of their behavior as a therapist.

Another group of researchers who early realized the educative value of multiple therapy were Haigh and Kell (1950). These researchers felt that multiple therapy could probably make its greatest contribution in the area of training counselors and therapists. In working with the technique, they found that it could be very helpful in implementing better communication and understanding between therapists, while at the same time have a favorable influence on the personal growth of the therapist.

Whitaker, Warkentin, and Johnson (1949) were also originally interested in the training implications of the use of multiple therapy. In their first paper on the subject, they state: "The long-range objective [of the procedure] was to develop concepts that would facilitate the teaching of psychotherapy" (p. 439). However, the interests of these researchers gradually went in the direction of therapeutic uses of multiple therapy. For example, in 1951, Warkentin, Johnson, and Whitaker published a study which described the treatment of 25 patients, each of whom was treated by anywhere from 2 to 10 therapists. They found in this study that the multiple therapy technique could not only favorably

affect the patient's therapy (greater therapeutic pressure in multiple therapy sometimes led to a more powerful and effective termination) but could also positively influence a therapist's capacity to work with patients. In later years these authors continued to research the therapeutic uses and effectiveness of multiple therapy. In a paper published in 1956, Whitaker, Malone, and Warkentin state that multiple therapy "has been a more effective form of treatment with all patients than individual psychotherapy" (p. 211). Unfortunately they presented no statistical data to substantiate this finding. It is also interesting to note that by 1956, they were at the point of rejecting the idea of using multiple therapy as a training technique for student therapists.

The final influential figure to be discussed in regard to the early history of the technique is Rudolf Dreikurs. Dreikurs' research emphasis was also on the treatment implications of multiple therapy. One of this researcher's major contributions to the area was his work on employing multiple therapy as a therapeutic consultation technique (Dreikurs et al., 1952a). By consultation, Dreikurs (and his co-researchers) was referring to a situation where at times a consulting therapist would be a participant in an interview (along with the primary therapist and patient) while at other times the therapy situation would just involve the primary therapist and the patient. These consultations, which began at the inception of therapy and continued until

termination, varied from every other interview to every fourth or fifth interview. Dreikurs et al. found that this practice increased the accuracy of diagnosis, interpretation and choice of procedure. These researchers also believed that such consultation would be helpful in resolving an impasse.

Thus, we find that in tracing the early history of multiple therapy, research was soon begun both in the area of therapeutic effectiveness and advantages of the technique, and in the area of training possibilities involved in the use of multiple therapy. It is interesting to note that though many of these studies drew general conclusions, not one study presented any statistical data to substantiate such conclusions.

The Uses For Multiple Therapy

Multiple therapy has been studied in a large number of very different therapeutic situations and with many different types of patients. Probably the widest research of multiple therapy has been in group therapy situations (Mintz, 1963b; Lundin and Aronov, 1952; Demarest and Teicher, 1954; etc.). Many varied techniques, ranging from psychodrama (Godenne, 1964) to activity group therapy (Kassoff, 1958), have been implemented by multiple therapists in group settings. The leadership teams for group therapy have also varied considerably. For example Solomon and Solomon (1963)

report multiple group therapy with a father and son as leaders, Fink (1958) discussed a husband and wife team, and Dreikurs et al. (1952a) report group therapy under the leadership of a senior and junior psychiatrist. Multiple therapy has been used with individual couples having marital difficulties (Linden et al. 1968) and with groups of couples with this type of problem (MacLennan, 1965). Another implementation of the technique has been with an individual family (Sonne and Lincoln, 1966) and also with groups of families (MacLennan, 1965). Finally, multiple therapy has also been employed with individual patients (Whitaker, Malone & Warkentin, 1956; Lott, 1957; Kell & Burow, 1970; etc.). Thus, multiple therapy has been used in many types of group therapy, and also with individual patients, couples, and families.

The types of patients studied in multiple therapy research have also varied considerably. For example, Kell and Burow (1970) have found that multiple therapy is indicated for patients whose life history shows some kind of impaired relationship with parents. They have also found this treatment helpful with patients who show a strong preference for the parent of the opposite sex. These authors also believe that multiple therapy is the treatment of choice for emotionally labile patients.

In looking at patients in a more traditional diagnostic fashion, we find that the technique has been used with schizophrenics (Sonne and Lincoln, 1966; Warkentin and Taylor,

1968). There are also other reports in the literature of the use of this technique with psychotics (Gans, 1962; Dyrud and Rioch, 1953; and Cameron and Stewart, 1955). Besides patients with psychotic disorders, there is research concerning the use of this technique with anxiety and hysterical neurosis (Whitaker, Malone, and Warkentin, 1956), with severe alcoholism, psychosomatic disabilities, and serious character disturbances (Greenback, 1964), and with chronic psychoneurotic patients (Cameron and Stewart, 1955). Other diagnostic groups for which the technique has been employed include homosexuals (Hill and Strahl, 1968; Singer and Fischer, 1967), children who for a variety of reasons cannot relate to others (Gans, 1962), and children of subnormal intelligence (Buck and Grygier, 1952). Finally, the technique has also been employed with juvenile delinquents (Kassoff, 1958; Perry, 1955).

Throughout the literature there are also suggestions as to when in the course of therapy (temporally speaking) this technique should be initiated. For example, Kell and Burow (1970) think that multiple therapy can be initiated in the beginning of therapy, after one or two interviews, or later in the therapy. Dyrud and Rioch (1953) recommend the use of multiple therapy as a middle section between two periods of individual therapy. It has also been suggested by Dreikurs (1950) that multiple therapy should be used on a consistent alternating basis with individual therapy. The model here would be: X number of individual sessions followed by one

multiple session followed by X number of individual sessions. Finally, there are others who believe that multiple therapy should be used from the beginning to the end of therapy (Whitaker et al., 1949; Hayward et al., 1952).

One of the most frequent recommendations regarding the implementation of multiple therapy is that this technique should be employed when there is an impasse. For example, Hayward et al. (1952) recommended the use of multiple therapy for very sick patients in a type of impasse "where the transference will build up to such a point of intensity that it becomes illusional" (p. 244). Dyrud and Rioch (1953) also think this technique should be used "...especially at those particular times when individual therapy seemed to be at a standstill" (p. 21). Others who recommend multiple therapy when an impasse occurs are Kell and Burow (1970), Dreikurs et al. (1952b), and Whitaker et al. (1950). One reason why multiple therapy can be successful in impasse situations is that a second therapist can bring a new perspective into the process, which can be helpful in resolving the impasse (Dreikurs et al., 1952a). In explaining why they think multiple therapy can be helpful in resolving impasses, Whitaker et al. (1950) state:

> The presence of the consultant is also valuable because he is able to carry part of the responsibility for the patient, so that the therapist can express what he had suppressed from fear of his own immaturity (p. 645).

In researching this technique with a wide variety of patients in many different psychotherapeutic situations,

some investigators have concluded that there are certain contraindications for using multiple therapy. For example, Kell and Burow (1970) believe that multiple therapy should not be used with: (1) people whose capacity to relate at all is seriously impaired (e. g. intellectualizing compulsive), (2) overtly hostile clients with little control over hostility, and (3) clients whose only resource is to depend on the therapist. Buck and Grygier (1952) indicate that the technique is contraindicated with very inhibited shut-in patients. MacLennan (1965) believes that multiple therapy is contraindicated with children in groups who are suffering from neurotic, borderline or behavior problems. MacLennan has observed that when there are two therapists, only one therapist actually works with the children, while the other therapist usually just spends his time standing around and watching.

Significant Features of Multiple Therapy

After reviewing the definitions, early history and possible uses of the multiple therapy technique, we will now turn to the dual question of what are the significant aspects of the process of multiple therapy and how do these aspects contribute to the efficacy of the technique.

Transference in Multiple Therapy

One area of the multiple therapy psychotherapeutic process that many researchers have concentrated on is the uniqueness here of the transference development. In discussing transference, Greenson's definition (1967) will be used:

> Transference is the experience of feelings, drives, attitudes, fantasies and defenses toward a person in the present which do not befit that person but are a repetition of reactions originating in regard to significant persons of early childhood, unconsciously displaced onto figures in the present (p. 171).

Many researchers believe that the multiple therapy situation, be it in individual or group therapy, can be symbolically looked upon as a family situation (with a mother, a father, and a child or children represented by the two therapists and the client(s) respectively). For example, Kell and Burow (1970) state that the multiple therapy situation "recapitulates the client's relationships with his parents in the simplest form" (p. 203). Lundin and Aronov (1952) also believe that a multiple therapy group simulates a family group. Another group of researchers who look upon the multiple therapy situation as a symbolic family are Whitaker et al. (1956): "It thus resembles that family where the adequacy and maturity of both parents is available to the child" (p. 212). Many researchers believe that the symbolic family created in the multiple therapy situation significantly aids the client's transference development. For example, Singer and Fisher (1967) think that

the co-therapists "provide a clearly delineated representation of the parental dyad which allows the projection of marked transference distortions" (p. 51). Similarly, Dyrud and Rioch (1953) look at multiple therapy "...as a method of therapy for rapid and effective clarification of difficult transference and counter transference problems" (p. 26). Greenback (1964) also thinks this method can speed the development of transference.

Although many researchers agree that multiple therapy is helpful in developing and working on transference, there does seem to be some difference of opinion as to why the client makes progress in multiple therapy as a result of the transference. Buck and Grygier (1952) believe that the multiple therapists

> may create the image of the loving and understanding parents whom he [the client] has never had but for whom he longed. In that case joint treatment may strengthen the bond and bring a much more rapid recovery than individual sessions alone (p. 719).

Sonne and Lincoln (1966) think that progress is made as a result of the transference, since when such transference is worked through, it can in turn lead to a healthy internalyzed self image. Another opinion as to why transference is so helpful in multiple therapy is given by Hill and Strahl (1968), who state that: "By reintroducing a simulated family triad, the client could have an impact on both therapists as he had not had with his parents" (p. 97). Another opinion on this issue is given by Dreikurs et al. (1952b) who, in

implying the benefits of transference development, state that: "The expansion of therapeutic roles can thus aid materially in the resolution of certain prominent conflicts which trace their origin to the formative years of family life" (p. 591). Kell and Burow (1970) also shed some light on this transference-progress equation in that they believe that multiple therapy allows the client to interact with two parental surrogates, who will recreate the earlier conflict in such a way that the client will be able to experience the feelings that characterized the earlier relationships. These researchers indicate that once the client has experienced these relationships, they can then learn new ways of interacting.

Other researchers believe that transference development and its relationship to problem resolution is materially affected when the therapists are of the opposite sex. Mintz (1965) states: "It seems to be accepted as an axiom that every patient must work through problems originating in a two-parent family, and therefore joint treatment by a male and female therapist seems a natural and almost inevitable development" (p. 293). Hulse et al. (1956) also believe that the use of opposite-sexed therapists is quite important:

> The factor of double sexually heterogeneous leadership representing both parental figures seemed to have facilitated the reproduction of the patient's earlier conflicts which may have been more difficult to evoke in individual therapy (pp. 433-434).

Demarest and Teicher (1954) similarly think that:

> The technique of using co-therapists of different sexes gives the patient the material with which he can structure present and past situations, work through conflicts in these situations and learn new patterns of behavior to realize his potentialities in these situations (p. 201).

Orange (1955) however does not think that the use of opposite-sexed therapists is that important: "Whether or not the co-therapists are of the opposite sex, it appears that they enable the group to assume the aspects of a family milieu..." (p. 81). Orange's observation might be explained by the idea that whether or not the therapists are of different sexes, the clients will unconsciously perceive them as such (Mullan and Sanguiliano, 1960).

Although many researchers believe that the patient is transferring feelings about his parents to the therapists, Lott (1957) thinks that the therapists could be the target for feelings developed from a client's relationship with such other people as grandparents, friends, or siblings.

Although the majority of researchers suggest that multiple therapy can be helpful in transference development and working through, there are at least two researchers who do not think that the development of transference in multiple therapy is so beneficial to the patient. For example, Slavson (1960) states that:

> Psychotherapy requires that the universal ambivalent feelings toward parents and parent surrogates be worked through. This can be done only with one target of transference feelings and not when they are split off (p. 226).

Gans (1962) also expresses some doubts about the advantageousness of transference development in that he states, "it is dubious whether realistic reproduction of early parent-child conflicts provides a salubrious climate for therapeutic insight" (p. 82).

Opposite-Sexed Therapists in Multiple Therapy

In discussing transference, we found that some researchers have theorized that the use of opposite-sexed multiple therapists seems to be a significant factor in aiding the development of the transference and the ensuing working through of certain conflicts. Other researchers have found that the use of opposite-sexed therapists can also affect the therapy process in other ways.

One situation in which opposite-sexed therapists seem to affect the process is when the patient is having problems concerning his/her sexual identity. Mintz (1963b) indicates that such problems can be better worked on when there are two opposite-sexed therapists in a situation who are both clear about their own identities and happy with them. When such a team of therapists is treating a client, Mintz thinks that there is a good chance that the client will intraject this sexual self-acceptance. Similarly, Kell and Burow (1970) think that the "clarity and preciseness" of the therapists' behavior as male and female can be helpful since "enhancing and clarifying the meaning of sexual identity is therapeutically important for clients" (p. 231).

It should definitely be recognized that the effectiveness of opposite-sexed therapists (as discussed by Mintz and Kell and Burow) may be due to the fact that the client is using the therapists as models of healthy behavioral functioning. This possible influence of modeling will be elaborated upon in the next section.

Another way in which opposite-sexed therapists can affect the process is when clients are questioning the limitations of their male or female role. For example, Mullan and Sanguiliano (1960) state that the use of different-sexed multiple therapists "may have brought forth and challenged more quickly all the cultural stereotypes [that the client has] concerning our being man and woman" (p. 563). Mintz (1965) not only thinks that different-sexed therapists can help the patient challenge fantasy stereotypes, but that "patients of both sexes can find in a co-therapy group evidence that it is possible to be either masculine or feminine without giving up basically worthwhile human qualities" (p. 295).

The use of different-sexed therapists can also have a positive effect on the therapy process in other ways. For example, Hill and Strahl (1960) believe that different-sexed therapists can be quite helpful in working with an hysteric where the dynamics include a father-daughter relationship characterized by early sexuality and a mother-daughter relationship that was cold and conflictual. With different-sexed therapists, there can be a focus on developing a

satisfying relationship with the male therapist without pervasive sexual overtones. As a result, the client may then accept the woman therapist and not feel competitive and/or defended against her.

Kell and Burow (1970) think that the different-sexed therapists can also be helpful in dealing with repression, since they have observed that "the female [offers] a way to exacerbate the repressed or denied emotions . . . while the male [offers] a way in which the repressed emotional components can be experienced, yet controlled" (p. 233).

Modeling in Multiple Therapy

When we examined the research concerning the use of different-sexed therapists in transference development and the resolution of certain other problems, it was said that some of the effect on the therapy process might have been due to the fact that the client used the therapists as models of more healthy functioning. After examining the literature of multiple therapy, it can be said that the client's observations of his "therapists-models" might also benefit the client in other ways. For example, Dreikurs et al. (1952b) state that the relationship between the two therapists "shows the patient a good human relationship where two individuals can and do have an interpersonal relationship based upon mutual respect" (p. 595). These authors think that such a relationship can help the patient learn the art of cooperation and the fact that he can be wrong without

losing status. One of the ways the clients obviously learn this is by seeing the therapists disagree and then successfully resolve the disagreement. In a specific reference to the client's observation of therapist disagreement, Kell and Burow (1970) report that the model of a good relationship between therapists can be helpful in teaching the client that disagreement can be helpful rather than being a painful punishing experience. Dreikurs et al. (1952b) believe that the patient seeing the therapists disagree can also be helpful in alleviating the patient's unrealistic perception of the therapist as an omnipotent being. Singer and Fisher (1967), who had quite successful outcomes with a group of homosexuals, report that through observing a healthy relationship between a male and female therapist, the patients can also learn that the threatening and destructive marriage that their parents had accustomed them to does not have to be the relationship that they themselves will have with a spouse. Linden et al. (1968) echo these sentiments, in that they believe that the wholesome cordiality between therapists should serve as a model--akin in some respects to a good marriage. Finally, Mullan and Sanguiliano (1960) in implying the effect of the therapists' relationship, hypothesize that: "Perhaps it is one therapist wanting to be with the other and their satisfaction in being together that is therapeutic" (p. 563).

In his critique of multiple therapy, MacLennan (1965), in an implied reference to the "modeling factor," warns that

"If the relationship between the male and female adults who lead the group is going to be the focal point of treatment, then this relationship has to be very carefully fostered and the partners chosen carefully" (p. 158). MacLennan then goes on to imply that he does not give as much significance to modeling in multiple therapy as do other researchers. Although MacLennon thinks that a patient's observations of a man and woman cooperating closely might be very important, he also believes that a school or recreational setting might be a more appropriate and less costly environment for such observations to take place.

The Natural and Contrived Roles of Therapists in Multiple Therapy

Another facet of the multiple therapy technique that seems to significantly affect the process is the fact that there are two therapists (instead of one) present who can play different contrived or non-contrived roles (psychologically speaking the therapist is always maintaining a role, even if it is not contrived) in their effort to deal with and clarify the patient's communications, fears, ambivalencies, and resistances.

Solomon et al. (1953) present one possible set of contrived roles the therapists can play. They state:

> The co-therapist method will produce optimal results when the personalities and orientations of co-therapists are flexible enough to permit considerable variance along the active-passive, directive-non directive continua (p. 177).

Dreikurs et al. (1952b) also suggest that in order to provide many experiences for the patient, one therapist can "play" a directive role, while the other can be non-directive. Another possible set of contrived roles is suggested by Treppa (1971), who thinks that one therapist can represent the reality principle while the other therapist can present a role more in keeping with the patient's fantasies. Mintz (1963b) does not suggest contrived roles but instead thinks that the therapists' insights, abilities and other assets will affect the group more than either of the therapists could do alone. Dreikurs (1950) also believes that just the therapists' different personalities (natural roles) can significantly contribute to the effectiveness of the multiple therapy team. Dreikurs has observed that the natural variations in the therapists' personalities will tend to almost "automatically" supplement each other in patient-therapist relationships.

The fact that therapists assume natural or contrived roles in multiple therapy can have varied effects on the patient. For example in the area of patient-therapist communication, Gans (1957) states that "with two therapists of opposing dispositions, the interaction is more simply and directly clarified" (p. 622). Kassoff (1958) has observed that having co-therapists with different personalities can also be advantageous since such differences will "present a wider range of adult reactions to which the group can adjust" (p. 73). According to Demarest and Teicher (1954), the

therapists can also affect the therapeutic process by partially playing the role of participant observers:

> By having two observers who can view the same phenomenon from different angles, it is possible to more accurately oppose the stimulus field existing in the group at a given time and thus to distinguish between reality reactions and transference reactions (p. 201).

The effect of therapist roles and most especially the effect of a second therapist (with all the additions in possible roles) is implied by Dreikurs et al. (1952a) when they state that "The presence of the second therapist is often disturbing enough to the situation so that the patient is more likely to exhibit more fully his disturbed relations with people" (p. 222).

As the therapists can affect the process through the use of contrived or natural roles, so can the patients affect the process through their perception of the therapists and the roles they believe the therapists are playing. (This of course is another way of looking at the transference situation.) Mintz (1963b) describes this particular patient behavior when she states:

> Often the patient relates to one therapist with relative consistency, perceiving him with minimal distortion, while working through a series of vehement, irrational and often dramatic transference reactions to the other therapist (p. 129).

Mintz thinks that by acting in such a fashion, the patient is, many times, projecting onto the therapist things he does not like in himself, while at the same time having a second therapist present for support so he can work this through.

This idea of another therapist's presence acting as a supportive influence while the patient presents hostile feelings to the other therapist, is also found in the research of Warkentin, Johnson, and Whitaker (1951), and is sometimes termed "splitting the transference." Greenback (1964) looks at the effect of patient perception of therapist roles in a slightly different way, in that he believes the patient might feel his own rage is more acceptable if there is more than one person to accept it.

This use of roles by the therapists and the perception of these roles by the patient also seems to be effective in helping the patient to resolve his ambivalencies in certain conflictual areas. For example Hayward et al. (1952) believe that this process can be most helpful in dealing with the schizophrenic patient's ambivalencies. Before therapy, the schizophrenic's ambivalencies (i.e. on the love-hate dimension) are felt so strongly that they tend to neutralize each other, which in turn usually leads to the symptom of flattened affect. However, Hayward et al. believe that, "When two or more physicians are present, the patient can split up his feelings, so that strong affection is expressed for one physician and hostility for another" (p. 244). Once this splitting is accomplished, there is the possibility for the integration of conflicting forces in the schizophrenic's personality. Similar dynamics are described by Adler and Berman (1960) with a delinquent adolescent population. In this case, one therapist played a very authoritative role,

while the other therapist was non-authoritative. This clear and definitive situation was set up, since the authors felt that delinquents had a very low tolerance for ambivalent situations. Other researchers who have found the technique of multiple therapy helpful in resolving ambivalency include Greenback (1964), Whitaker et al. (1956), and Kell and Burow (1970).

One set of major criticisms against the use of contrived roles by therapists has been voiced by Treppa (1971). Treppa thinks that situations where one therapist acts passive and supportive, while the other therapist acts aggressive and dominant are: (1) artificial in nature, (2) limiting on the therapists' freedom to grow, (3) depersonalizing the patient by depersonalizing the therapist, and (4) feeding into cultural stereotypes about how a man and woman should feel.

Similarities Between Group Therapy and Multiple Therapy With an Individual Client

Another significant feature of the process of multiple therapy to be discussed here, is the fact that when multiple therapy is conducted with an individual patient, the situation resembles in some ways a group environment. This resemblance seems in part responsible for the greater efficacy of the multiple therapy technique. For example, Reeve (1939) states that:

> We enable the patient to evaluate his problem in relationship to an artificial group--a group in which the prime concern is that of assisting him to utilize his environment as it exists, for greater satisfaction and less discomfort (p. 747).

Dreikurs (1950) also looks at multiple therapy with an individual patient and group therapy as sharing similar dynamics which might be helpful for the patient. Dreikurs thinks the two methods share such efficacious therapeutic factors as: (1) the patient in both situations is in the position of an observer of, and listener to, discussions concerning his problems, dynamics and attitudes, (2) in both therapeutic environments there is a less than personal relationship between patient and therapist, and (3) there is an atmosphere of a more objective approach. Thus, both of the above authors think that this resemblance of multiple therapy with an individual patient to group therapy is a contributing factor to the success of the technique.

Thus far, we have discussed such significant process aspects of multiple therapy as transference, the use of opposite-sexed therapists, modeling, the use of therapist roles, and the similarities of the technique to group therapy. In this discussion we have also shown how certain of these significant features relate to certain advantages found in the use of this technique. In concluding this section, we will now present some other advantages that seem almost solely due to the simple fact that there is more than one therapist present with the patient. One such advantage is

that the patient does not seem to get as involved here in depending too much on one therapist (Dreikurs et al., 1952a). Mintz (1965) also thinks that extreme dependency on one therapist is less likely in multiple therapy. Mintz (1965) and Dreikurs et al. (1952a) think that this lack of extreme dependency on one therapist hastens termination. Another advantage that might be attributed solely to the use of more than one therapist is that as the patient progresses, there is the potential that he will get more positive feedback than he would get with an individual therapist (Warkentin, Johnson, and Whitaker, 1951). These authors report that such positive feedback can be quite beneficial for the patient, in that it can give him a feeling of confidence or cultural acceptance. Another advantage reported by Warkentin et al. (1951) is the fact that more than one therapist increases the potential therapist responsiveness to the patient. That is, there is a better chance the patient will be heard and by implication, understood, by at least one therapist. Finally, another advantage attributed to the use of more than one therapist is that therapy does not have to stop when a therapist is sick or goes on vacation (Greenback, 1964).

Criticisms of Multiple Therapy

In the preceding section, although certain criticisms were stated when they were pertinent, the majority of the

research described why and how multiple therapy might be quite helpful in the treatment of a patient(s). However, as is true for most therapeutic techniques, there is also a significant portion of the literature here that addresses itself to the disadvantages to the patient that might be inherent in the use of multiple therapy. This criticism of multiple therapy falls into such areas as the effects of therapist-therapist relationships on the patient and the disadvantages to the patient created by practical-administrative problems. These criticisms will now be presented.

In a previous section we saw how a healthy and cooperative relationship between the therapists might be quite helpful to the patient as a model and for working on transference. On the other hand, there is the criticism that multiple therapy can negatively affect the therapeutic process when (as a result of many factors) co-therapist relationships are marked by competition, friction, or antagonism. Mintz (1965), in addressing herself to the issue of therapist-therapist friction, states: "The possibility of personal friction between the therapists is certainly the greatest hazard of this type of treatment" (p. 299). Lott (1964) thinks that such things as dominance struggles or significant competitiveness can also adversely affect the therapy. Among others, Solomon et al. (1953) are also in concurrence that the effects of therapist-therapist

antagonism can certainly be a disadvantage of using this technique.

In looking at causitive factors for such antagonism, Solomon et al. (1953) suggest that such antagonism could be the result of differences in orientation between the therapists (i.e. differences in therapeutic approach on such dimensions as passive-active, and directive-nondirective), which might in turn be due to differences in training, environment, or personality. These authors think that antagonism and/or hostility might also be due to one therapist finding a topic threatening and the other not finding it so. These authors also believe that antagonism can be the result of one therapist being a student while the other therapist is more experienced (competition, of course, would also be a factor here). Warkentin et al. (1951) also believe that a student therapist - experienced therapist relationship could engender antagonism or competitiveness between the two. Gans (1962) implies a causitive factor for problems in the therapist-therapist relationship when he states that a lot of the literature indicates that "...co-therapists are preoccupied with their relationship vis-a-vis each other" (p. 82).

The possible effects on the therapeutic process of problems in the co-therapist relationship are varied. One possible effect could be that if the patient saw antagonism or competitiveness developing between the two co-therapists

he could try to play one therapist off the other (Solomon et al., 1953; Mintz, 1965). Another possible effect of hostility, competitiveness, etc. between therapists is that it can create anxiety (Kassoff, 1958) or conflict and confusion in the patient (Kell & Burow, 1970). Solomon et al. (1953) believe that such hostility might also adversely affect the process if instead of being expressed directly, it is displaced to the patient. Warkentin et al. (1951) believe that such indirect expressions of antagonism can serve to cancel out the effectiveness of the therapists and make them less useful to the patients.

Probably one of the most significant effects of co-therapist conflicts is how such conflicts can affect the transference here. For example, Lundin and Aronov (1952) believe that if the patient sees a conflictual relationship between therapists (i.e. he sees the same lack of respect, disharmony, and competition he saw between his parents), the transferential process will be hindered. Mintz (1965) also speaks to this issue when she states that if tension is occurring between the co-therapists "...one of them may be secretly delighted to find a patient seeing him as all good and his colleague as all bad" (p. 298). It seems likely that such an occurrence would not beneficially affect the patient. Thus, both Lundin and Aronov, and Mintz either state or imply that co-therapist conflicts can adversely affect the transference development, which many researchers believe is quite important to the success of the technique.

Although most researchers think that conflicts between therapists must be worked through, there is some disagreement as to how this should be accomplished. For example, Kell and Burow (1970) believe that these disagreements should be worked through in front of the patient and can even serve as a model for how to cope with disagreements. Mintz (1965) also believes that these disagreements should be dealt with in front of the patient. Mintz feels that the patient's observation of a disagreement between the two therapists can help clients "realize that they are dealing with real people and not with primitive magic parent figures of infancy" (p. 299). Although Hulse et al. (1956) agree that conflicts between therapists should definitely be worked through, they think that this is best accomplished outside the group.

Besides discussions concerning disadvantages to the patient resulting from conflictual therapist-therapist relations, there has also been criticism of this technique on the practical-administrative dimension. Probably one of the most frequent criticisms of the technique in this area is that it is too expensive in long-term individual therapy for the patient to pay for two therapists (Dyrud and Rioch, 1953; Greenback, 1964; Mintz, 1965; MacLennan, 1965). However, Whitaker et al. (1956) in answer to this criticism state that "In a considerable number of cases it appears that the total financial cost to the patient is less than the cost of individual therapy with similar patients because of the

comparative brevity of multiple therapy" (p. 211). These authors go on to say, however, that this has not been statistically documented. Hayward et al. (1952) also make the point that "...it would appear that the increased pace of treatment [of multiple therapy] will, in most cases, more than offset the expense" (p. 245). However, as with Whitaker et al., there is no statistical documentation to substantiate this claim. Thus, the validity of the cost criticism has not yet been determined.

Another criticism of multiple therapy is that in the beginning of therapy some patients seem to experience certain difficulties in adapting to the technique. For example, Dreikurs et al. (1952b) state that they found some patients reluctant and suspicious about the technique. Warkentin et al. (1951) report that many patients are most anxious and tense especially in the first stages of therapy. These authors, who used anywhere from two to ten therapists in the treatment of a patient, think that many patients either implicitly or explicitly ask the question: "Am I that sick that I need so many therapists?"

Other criticisms of the technique on the practicality dimension are: (1) The multiplicity of relationships here may lead to confusion and maladaptive ways of coping (Kell and Burow, 1970); (2) The idea that therapists are interchangeable (that is, when one therapist is away, therapy can continue) can lead therapists to feel that there is no need

to help patients discuss their feelings about a therapist's absence (MacLennon, 1965); and (3) The technique has many administrative problems (Greenback, 1964).

Research and Multiple Therapy

Many authors have noted that multiple therapy is a therapeutic approach that offers many research possibilities (Dreikurs et al., 1952b; Warkentin et al., 1951). In a pertinent discussion of the advantages of multiple therapy as a medium for research, Haigh and Kell (1950) state that by using this technique, the researcher can best separate the effects of counselor personality from effects of different therapeutic situations in analyzing counselor behavior. These authors also mention that the technique might be quite useful in studying the effectiveness of different therapeutic approaches.

It is interesting to note that although many authors have recognized the potential for quality research in this area, there are actually very few studies in the literature that even so much as hint at statistical documentation. For the most part the research in this field has consisted of a lot of case studies, personal observation, and theorizing concerning the potentialities of multiple therapy. However there are some exceptions to this research situation. Beside the already described study by Warkentin et al. (1951), there is the study by Mallars (1968), which compared the use

of the counseling team approach (multiple therapy) to individual therapy. Perhaps the major finding here was that clients, counselors, and supervisors were significantly more satisfied with the team approach than with individual therapy.

Another exception here is the study by Nunnelly (1970). This researcher compared therapy groups run by a male leader, a female leader, and a heterosexual team of two therapists. Nunnelly hypothesized that multiple therapy groups would show more improvement than groups led by an individual therapist on the following dimensions: (1) perceptions of father acceptance, (2) perceptions of mother acceptance, (3) increase in ego strength, (4) increase in self-acceptance, and (5) decrease in social introversion. Nunnelly found no support for hypotheses 2 through 5. He did find significant differences on the first hypothesis between the multiple group and the group led by a male therapist. However, no differences were found between the multiple group and the female-led group on this dimension.

Finally, one of the other exceptions to the dearth of empirical research in the multiple therapy literature is the work by Singer and Fisher (1967). These researchers found that a homosexual group led by two opposite-sexed therapists brought about such changes in the clients as: (1) marked decreases in homosexual activity, (2) increases in heterosexual dating, (3) increases in work efficiency,

and (4) decreases in self-destructive behavior. However, of these four studies, only the works by Nunnelly and Mallars present any statistical documentation. It is important to note in this context that the lack of statistical documentation coupled with claims for the success of multiple therapy, is incredibly prevalent in the literature. For example, Mintz (1965) states: "The principal technical value of co-therapy is perhaps that it seems to accelerate change" (p. 296). Similarly, Whitaker et al. (1956) state: "It [multiple therapy] has been a more effective form of treatment with all patients than individual psychotherapy" (p. 211). Neither of these researchers presented any statistical data to substantiate these claims.

Besides this lack of statistical documentation, there is also in most multiple therapy research the absence of many other elements that go into the making of quality research. Meltzoff and Kornreich (1970) present five criteria that they feel should be fulfilled if a psychotherapy study is to be considered adequate:

> (1) freedom from major design flaws that might invalidate the conclusions; (2) use of an appropriate control group and adequate sampling; (3) relative freedom from bias; (4) employment of reasonably objective, reliable, and valid criteria measures; (5) presentation of suitably analyzed and interpreted data (p. 76).

There is not one study of multiple therapy that has been reviewed by this author that adequately fulfills these criteria.

Thus, it seems obvious that more objective, statistically-based research, especially with regard to the efficacy of the technique, is definitely needed in this field. It will be one of the aims of the present research to begin the attempt to fulfill this need.

METHODOLOGY

Subjects

Clients

The clients that took part in this project shared certain demographic characteristics. All the clients were unmarried female students at the University of Florida. They were all between the ages of 18 and 23. Every client in the study had presenting problems concerned with interpersonal difficulties. Finally, no client involved in this project had previously had any formal psychotherapy. During the intake phase of the study, every University of Florida student that came to the University Counseling Center for personal rather than vocational counseling, and that fit the above demographic characteristics, was asked to take part in this project. A total of 24 clients completed all phases of this study.

Therapists

A total of twelve therapists at the University Counseling Center, University of Florida, participated in this study. Six of the therapists were male and six were female. The therapeutic orientation of the therapists involved could be termed "eclectic." Six of the therapists (three males

and three females) were relatively inexperienced, and had less than two years of prior counseling work. The other six therapists (again three males and three females) were relatively more experienced, with all having between three and five years of prior therapy experience. All of the therapists involved had only quite limited experience with the multiple therapy treatment modality.

The twelve therapists were not randomly selected due to the limited number of therapists at the Counseling Center and certain requirements of the study. Instead, the therapists were selected by the two researchers and the director of the Counseling Center.

For the multiple condition of the study, the 12 therapists were broken down into six pairs. In three of these pairs, there was a relatively inexperienced male and inexperienced female therapist. Each of the other three pairs consisted of an experienced male and female therapist. It should be noted that none of these pairs of therapists had ever previously worked together. The decision as to which therapists should be paired together was determined by the two researchers in coordination with the director of the Counseling Center. The only specific rule followed was that each male therapist had to work with a female therapist who had approximately the same amount of prior therapy experience. When a therapist agreed to take part in the project he was asked if he thought he could work well with the other

therapist that was to be paired with him. All therapists readily agreed to work with their predetermined co-therapists.

Instruments

Personal Orientation Inventory

The Personal Orientation Inventory (POI) was developed by Shostrom (1964, 1966b) to measure a client's positive mental health or level of self-actualization. This instrument was utilized in the present study as a measurement of client change in self-actualization from pre- to posttherapy. The inventory, which consists of 150 two choice items, requires the client to make comparative value and behavior judgments.

Scores from the inventory are in the form of two basic scales of personal orientation and ten subscales, each of which, according to Shostrom (1966b), measures an important facet of self-actualization. In the present study, the two basic scales and four of the ten subscales were utilized. The two basic scales are termed Time Competent (Tc) and Inner Directed (I). The Time Competent scale measures the extent to which a person lives in the present rather than in the past or future. According to this scale, a ratio of 1:8 for living in the past or future versus living in the present should be achieved by a person who is self-actualized on this dimension. The scale of Inner Directedness measures a person's autonomy, self-supportiveness and individuality.

According to the scale, a ratio of 1:3 for being other directed versus being inner directed should be obtained by people who are self-actualized on this dimension. The four subscales used were the Self-Actualizing Value scale (SAV), the Self Acceptance scale (Sa), the Capacity for Intimate Contact scale (C), and the Acceptance of Aggression scale (A). The SAV scale measures the extent to which a person holds the values of self-actualizing people. The Sa scale is concerned with how much a person accepts himself in spite of weaknesses. The C scale measures the ease or difficulty a person has with warm interpersonal relations. Finally, the A scale measures the ability of the client on the dimension of acceptance of feelings of anger or aggression. (See Appendix A for a description of all the POI scales.)

A client's inventory is scored by adding up the number of items endorsed on each scale or subscale (raw score). If necessary, these raw scores can be easily converted into standard scores through the use of a POI profile sheet. Since the use of raw or standard scores would yield the same statistical results, it was decided in the present study to utilize raw scores.

Reliability of the POI has been shown to be reasonably high. For example, Klavetter and Mogar (1967a), in their study of college undergraduates, found test-retest reliabilities of .71 and .84 for the two major scales of Time Competence and Inner Direction. As would be expected, some

of the test-retest reliabilities on the subscales were lower, with the coefficients for the ten subscales ranging from .55 to .85. The reliability coefficients for the four subscales used in the present study were: .74 (SAV scale), .80 (Sa scale), .55 (A scale), and .75 (C scale). In another study of test-retest reliability, Shostrom (1964) found reliability coefficients of .91 and .93 for the POI.

Besides having reasonable reliability, the POI has demonstrated its efficacy in significantly discriminating between groups of persons clinically judged as being self-actualized, normal, and non self-actualized (Shostrom, 1964). All 12 scales of the POI have also been shown to significantly discriminate between patients entering therapy and patients in the more advanced stages (11-64 months) of the psychotherapeutic process (Shostrom and Knapp, 1966). Finally, Fox (1965) found that all of the POI scales significantly differentiated a sample of psychiatric hospitalized patients from a self-actualized sample, and a normal adult sample.

Self-Actualization Scale

The Self-Actualization Scale (SAS) was originally used as part of a number of research projects concerned with the long term psychological effects of subjects, who under controlled conditions, had ingested specified amounts of LSD (Klavetter and Mogar, 1967b; Savage, Harmon, Fadiman, and Savage, 1964). The original scale, which consisted of brief

statements regarding the experience of self-actualization, had been derived from a follow-up questionnaire given to 119 subjects who were in a psychedelic therapy-research program. The SAS was given to each subject at an average time of 9 months following the LSD experience. Klavetter and Mogar (1967b) report that during this average 9 month period, the subjects took part in many weeks of interviews, which were primarily concerned with recorded accounts of the LSD experience. These authors also state that during this procedure, emotional support, but not interpretive psychotherapy, was provided.

The Self-Actualization Scale reported on above consists of 45 items, which were rated by the subjects on a four point scale. (A rating of three implied that a statement designated a very accurate description of the total LSD experience, while a rating of zero implied that a statement was not at all descriptive of the experience.) Of the 45 items, 8 were considered non self-actualizing items, while 35 items were considered self-actualizing statements. In the study by Klavetter and Mogar (1967), 42 of the 45 items in the scale significantly discriminated between a group of "Peakers" and "Non-Peakers" (that is, a group who reported transient therapeutic benefits versus a group who did not).

Shapiro (1971) used a modified version of the SAS as a posttherapy questionnaire in a study concerned with the efficacy of "Traditional" versus "Marathon" group therapy.

This modified version consisted of 40 items, of which 12 were of the non self-actualizing type. The items were rated on a three rather than four point scale. Shapiro found that the scale significantly discriminated between people in "Traditional" group therapy and those in a "Marathon" group. Specifically, he found that people in "Traditional" group therapy became significantly more self-actualized (according to the SAS) than people in a "Marathon" group.

In the present study, a posttherapy SAS was used, which was a slightly modified version of the scale utilized by Shapiro (1971). The scale was utilized here in an attempt to determine if there were any differences in outcome, on the dimension of self-actualization, between clients in individual and multiple therapy. The SAS, which was just termed "Follow-up Questionnaire," consisted of 37 items, of which 26 were of the self-actualizing type and 11 were of the non self-actualizing type (see Appendix C). The self-actualizing items reflected: (1) increased spontaneity, expressiveness, and full functioning; (2) a sense of personal warmth and increased self-esteem; (3) a more accurate perception of reality, self, and others; and (4) less anxiety and freedom from restrictive or rigid behavioral patterns (Klavetter and Mogar, 1967b).

The items were rated by the clients in the present study on a three point basis (0 = "if the item is NOT AT ALL descriptive of myself," 1 = "if the item is SOMEWHAT ACCURATE

description of myself," 2 = "if the item is a VERY ACCURATE description of myself"). For data analysis purposes the scale was scored by reversing the ratings ascribed to the non self-actualizing items and then summing this score with the self-actualizing items so that the possible range of scores was 0-74.

Although the items of the SAS of Shapiro (1971), Klavetter and Mogar (1967b), and the items of the SAS used in the present study are all quite similar, the similarities in regard to item content are greatest between the SAS utilized in the Shapiro project and the SAS used in the present study. In comparing the items used, a large majority of the items are identical to the ones in the Shapiro SAS, while most other items in the present SAS only reflect minor differences in wording (compared to the Shapiro SAS) due to the fact that this project was investigating individual and multiple therapy, rather than group therapy. Three items from the Shapiro SAS were totally omitted due to their lack of pertinence for our project. The rating of the items in the present SAS was identical to the system used by Shapiro. However, the scoring system for the scale was originally devised by Klavetter and Mogar (1967).

Although the SAS has only been used as a follow-up questionnaire up to this time, an attempt was made in the present study to devise a pretherapy SAS (see Appendix B). The pretherapy SAS consists of 30 items, of which 24 are

of the self-actualizing type. The items in the pretherapy SAS are quite similar to those in the posttherapy SAS, in that most of the items are slight modifications of post-therapy SAS items. Modification was necessary, since the questionnaire was being devised for a population in a pre- rather than posttherapy condition. The three point rating system used in the pretherapy SAS was identical to the rating system in the posttherapy SAS. This pretherapy SAS was administered to the present sample prior to therapy. However, the scores from the pretherapy SAS are not included in Chapter III. This is due to the fact that the pretherapy SAS is still in a quite crude pilot stage, has a different number of items, and is somewhat different as far as item content goes. Thus, it could not be compared to the post-therapy SAS with regard to data analysis.

Problems List

The Problems List (PL) was utilized in the present study as a pre- to posttherapy measure (see Appendices G and H). It was used in order to determine both exactly what the client perceived to be her main problems or target psychopathology, and if these problems changed as a result of psychotherapy. Prior to the beginning of therapy, a client was asked to list and briefly describe (in writing) three major problems concerning herself and others that were bothering the client at the present time. When therapy had been terminated for a particular client, the client was

shown her original pretherapy Problems List. She was then given a posttherapy Problems List, which asked the client to briefly describe the status of the problems she had previously listed now that her therapy had been terminated.

After the 24 clients had completed both the pre- and posttherapy Problems Lists, the lists were rated by three intern-level psychologists. This rating was carried out in the following manner. A judge was given the pre- and posttherapy Problems Lists of the 24 clients. (The order of the 24 pairs of Problems Lists had previously been randomized.) The judge was asked to first read a client's pretherapy Problems List and then to read the posttherapy Problems List. He was then directed to rate the client's perceived degree of change on the posttherapy Problems List generally over all problems. It was emphasized that the judge was to rate the client's stated degree of change, and not his (the judge's) own impression of how much the client had changed. (See Appendix F for Directions for Rating Problems List.) The ratings by the judges were done on a five point scale: -2 = A Lot Worse, -1 = A Little Worse, 0 = No Change, +1 = A Little Improvement, +2 = A Lot of Improvement. The ratings by the judges were later converted to a 1 to 5 scoring system.

In order to check inter-judge reliability here, Pearson product-moment coefficients of correlation were computed between the three judges' ratings. These correlations are

presented in Table 1. The average of these correlations was .88.

For data analysis purposes, the three judges' ratings for a client were averaged. Thus, twelve averaged ratings (one rating for each client) were computed for the clients in individual therapy, which were in turn statistically compared to the twelve averaged ratings of the clients in multiple therapy.

TABLE 1

PEARSON PRODUCT-MOMENT CORRELATIONS BETWEEN THE THREE JUDGES' RATINGS OF THE PROBLEMS LIST

	Judge 1	Judge 2	Judge 3
Judge 1		.88	.91
Judge 2			.84

Battle et al. (1966) have researched the question of the efficacy of utilizing the client's stated degree of change on target complaints as criteria of improvement. These researchers have concerned themselves with investigating the reliability and validity of instruments that depend on target complaints as criteria of improvement.

On the question of validity, Battle et al. (1966) found that when clients gave three problems prior to therapy, and then rated these problems on a five point scale (of improvement) after four months of therapy, the resulting ratings

correlated significantly with all the other outcome measures used in the study. The other measures included instruments filled out by the therapist, the client, and an outside observer. The authors also found that the client's professed target complaints corresponded with those obtained in an intensive psychiatric interview.

Battle et al. (1966) also investigated the question of the reliability of this instrument. In one study clients were asked to list, rank in order of importance, and rate for severity their target complaints before and after an intensive psychiatric evaluation interview that involved no therapy. The authors found: (1) a significant correlation (.68) between the pre- to postranks on the original pre-complaints, and (2) that severity ratings of target complaints did not significantly change pre to post (before and after one interview). In another study dealing primarily with reliability, clients gave and rated (on severity) their target complaints to one researcher prior to an intensive psychiatric interview, and then gave and rated their complaints to a different researcher after the intensive interview. The above authors found that 14 of the 20 patients in the study had identical pre- and postseverity ratings, and that only 4 patients differed by more than one point (pre to post) on a twelve point severity scale. With regard to the question of the constancy of the content of problems over time, Battle et al. (1966) discovered that all of their

judges were in agreement that each of the target complaints of the client were present in the pre and post stated main problem of all 20 patients.

Pascal and Zax (1956) also believe that target complaints should be used to evaluate the success or failure of psychotherapy. Their rationale is based on the assumption that psychotherapy's purpose should be to effect behavior change. Following the stating of this assumption, they go on to say that behavior must therefore become the criterion for improvement.

Finally, Rickard (1965) gives another rationale for utilizing an instrument such as a problems list, in that this author thinks that the behavior to be changed by psychotherapy should be tailored to each individual. Rickard believes that this idea presents an alternative to the usually accepted concept of employing common criteria of change for the group.

Thus, it appears that an instrument such as the Problems List used in the present study has not only been advocated by numerous researchers, but has also been shown to be a reliable and valid outcome measure.

Scale of Helpee Self-Exploration in Interpersonal Processes

In the present study, the most recently revised form of the Helpee Self-Exploration scale (Carkhuff, 1969) was used in order to assess from a trained observer's point of view, the client's therapeutic process and progress in multiple

as compared to individual therapy. Truax and Carkhuff (1967) have defined self-exploration as being those attempts by the client to define and understand his own beliefs, motives, actions, and values.

Truax and Carkhuff (1967) have devised a method whereby this specific client behavior can be measured through the use of trained judges who rate taped segments of the client's therapy sessions on a scale of self-exploration. This scale was originally a nine point scale. However, Carkhuff (1969) later revised it into a five point scale. The revised scale was utilized in the present study. With regard to this five point scale, a rating of one (1) for a tape segment would indicate that the client was not discussing any personally relevant material, and might have even been actively evading such a discussion. In other words, the client showed absolutely no self-exploration. On the other end of the spectrum, a rating of five (5) would indicate that the client was spontaneously and actively involved in discovering feelings and experiences concerning himself and his world. That is, he was demonstrating a great deal of self-exploration. (See Appendix E for a complete description of the scale.)

This scale, along with the process scales of therapist empathy, respect, genuineness, and concreteness (see Kosch-Graham, 1972) have been shown to be reliably rated and have been validated in many psychotherapy studies (Truax and Carkhuff, 1967; Carkhuff and Berenson, 1967; Carkhuff, 1968).

Quite pertinent to the present study is the fact that the aforementioned research has shown that client self-exploration has a predictable and significantly positive relationship to therapeutic outcome (Truax and Carkhuff, 1967). It should also be noted that the above research has also demonstrated that experimental manipulation of therapist conditions (i.e. empathy) produces predictable and many times significant changes in the client's level of self-exploration (Truax and Carkhuff, 1967).

In the present study, two intern-level therapists rated taped segments from the first and last therapy sessions of each of the 24 client subjects. This task was made possible by the fact that all the therapy sessions for each client were on tape. Three segments were taken from each therapy session. These segments came from the first, the middle, and the last third of a session. Thus, each judge rated 3 segments from each of 48 different therapy sessions (a total of 144 segments). The order by which these 144 segments were presented to the judges was completely randomized, and had been previously recorded on six master tapes. Therefore, the judges did not know if the particular segment they were rating came from a first or last session. They also did not know from what part of a session the segment had come. However, due to the therapeutic conditions themselves, the judges were able to determine if a segment had come from a multiple or an individual therapy session. In order to do

the actual rating, the master tapes and 144 numbered index cards (each index card had a segment number which corresponded with the segment number on the master tapes) were given to the judges. The judges were then told to listen to each taped segment and then rate the segment on the therapist conditions of empathy, respect, genuineness, and concreteness, and on the client conditions of self-exploration. The judges were instructed to always rate each segment in the order as presented above.

The two judges that rated the tapes here had previously attained an inter-judge reliability of more than .80 as judges in research using the Truax and Carkhuff therapist scales (Swander, 1971). The Pearson product-moment coefficient of correlation between these two judges' ratings of client self-exploration in the present study was computed by using each of the two judges' ratings on 24 randomly selected taped segments. Twelve of the segments were selected from the multiple condition, while the other twelve segments came from the individual condition. The resulting Pearson product-moment correlation was .81 for client self-exploration.

Since each judge rated the first, middle, and last segment of each therapy session, each client was given six ratings of self-exploration for each session. The score for a client's session (be it the first or the terminating session) was an average of the six ratings. However, it should

be noted that for two of the client sessions, there were less than six ratings. This was due to the fact that in one case a terminating session was very short, while in another case, a client did not talk during a segment. In cases where there were less than six ratings, an average of the ratings obtained was used as the score.

Therapy Session Report

The Therapy Session Report, which has been used and validated in many psychotherapy studies (Orlinsky and Howard, 1966b, 1967), is designed to elicit information concerning how a therapist and a client both behave in and experience a psychotherapy session. There are two parallel Therapy Session Report (TSR) questionnaires: one for the client and one for the therapist. The items in the TSR, all of which are in a multiple choice form, focus on such facets of the therapy session as: dialogue (i.e. client or therapist discussion of certain topics), the therapeutic relationship, feelings of the therapist and patient, the exchange process (i.e. patient wants, therapists' goals, etc.), and session development.

The present study utilized a modification of the patient form of the TSR (see Appendix D).[1] This questionnaire consisted of 45 items that were selected from the original Orlinsky and Howard Therapy Session Report. The items that

[1]The Kosch-Graham dissertation (1972) utilized a modification of the therapist form of the Therapy Session Report.

were selected were primarily concerned with the client's attitudes, feelings and behavior toward the therapy sessions and the therapist(s) that was (were) involved in these sessions. This modified patient form of the TSR was employed in order to measure the influence of the variable of multiple versus individual therapy on a therapy session. In both the individual and multiple therapy conditions, the questionnaire was given to the client after she had completed one session of therapy and again after the last therapy session.

The items were rated on scales of 0 to 2, 0 to 3, 1 to 5, 1 to 6, and 1 to 7. Some examples follow:

"During this session I talked about relations with the opposite sex."

0: No

1: Some

2: A lot

"During this session, how much friendliness or respect did you show towards your therapist?"

0: Slightly or not at all

1: Some

2: Pretty much

3: Very much

As an example of a somewhat different type of rating, there is the question, "How do you feel about the session which you have just completed?"

This session was:

1: Perfect.

2: Excellent.

3: Very Good.

4: Pretty Good.

5: Fair.

6: Pretty Poor.

7: Very Poor.

All questions that had a 0 to 2 type rating always had the same word ratings (i.e. No, Some, A lot) corresponding with the numerical ratings. This was also the case for questions with the 0 to 3 type ratings. However, for questions with the 1 to 5, 1 to 6, or 1 to 7 type rating, the written responses corresponding to the numerical ratings were different for each question.

For questions with the 1 to 5, 6, or 7 type rating, the item was presented to the client in the opposite direction from which it was scored. For example, in a question that had a 1 to 6 type rating, a "1" response by a client was given a score of 6, while a "6" response was given a score of 1.

It should also be noted that in order to test two of the hypotheses, some of the items in the TSR were later grouped together for scoring purposes. For questions 2_{1-4} (see Hypothesis IVA) each response received a 0 for "No" and a 1 for either "Some" or "A lot." Thus, the possible range

of scores for this group of questions was 0 to 4. In the case of questions 26-38 (see Hypothesis IIB), the score for a client for this group of questions was the sum of her ratings on the 13 questions. Since each of these questions had a 0 to 2 type rating, the possible range of scores for this group of questions was 0 to 26.

Procedure

The procedure for this study was designed to compare both the efficacy and process of multiple versus individual therapy. More specifically, the primary purpose of the procedure was to elicit data concerning the therapeutic outcome of clients in multiple versus individual therapy. These data were obtained through the use of client reports on a variety of instruments and through the use of tapes rated by outside judges. The procedure was also designed to elicit information concerning the clients' attitudes toward the therapeutic conditions of multiple versus individual therapy. A client report instrument was also utilized in obtaining this information. Finally, this procedure was used in order to examine the clients' discussions in multiple as compared to individual therapy. Tape ratings and client reports were used for the investigation of this aspect of the therapeutic process.

Instruments filled out by the therapists involved in this study, and the data resulting from these instruments,

are not included in the present dissertation. This is due to the fact that the present dissertation concentrated on the client in therapy, while another dissertation using the same population (Kosch-Graham, 1972) primarily concerned itself with the therapist in the conditions of individual and multiple therapy. However, for the purposes of clarity and pertinency, some aspects of the Kosch-Graham (1972) methodology are included in the present dissertation.

Clients

Each client who participated in the project first took part in a half hour intake interview. This interview, which was given to all incoming clients at the Counseling Center, served the twofold purpose of obtaining basic demographic data, and of determining if the client's difficulties were of a personal or vocational nature. (Those clients with vocational problems were immediately excluded from the study.) If the client fit the predetermined characteristics for the study (e.g. unmarried, female, student, etc.), the intake interviewer told the prospective client that he would refer her to either one therapist or a pair of therapists. At the time of this interview, the interviewer also explained that one of the usual methods of psychotherapy employed at the Counseling Center was to assign a client to both a male and a female therapist.

If, after the intake interview, a client was deemed appropriate for the study, her name was given to the

researchers. At this juncture, a telephone contact to the prospective client was made by one of the researchers. During this contact, the researcher explained the nature of the study (see Information and Consent form, Appendix I) and then asked the client if she would be willing to take part in the project. If the client agreed to participate, she was asked to come to the Counseling Center at her earliest convenience to take a few short questionnaires. During the telephone contact, the client was also given the name of her counselor(s) and was told that an appointment would be made for her to see this counselor(s) at the time she completed the questionnaires.

The pretherapy instruments that were given to each client were the Personality Orientation Inventory, a Problems List, and a Self-Actualization Scale. These scales were given to each client who participated in the study. After the pretests had been completed, the client soon begun formal psychotherapy with her counselor(s).

The counselor(s) that each client was to see, and thus the type of therapy that the client would participate in (be it individual therapy or multiple therapy with an inexperienced or experienced male-female pair) was determined from randomized lists of the therapists and therapist pairs that had been constructed prior to the commencement of the study.

By prior consent of the client, each therapy session was taped. After the first session, the client was given

the patient form of the Therapy Session Report (TSR). The taped first session was later rated by judges on the scale of Helpee Self-Exploration. No other instruments were administered to the clients until after the terminating session. It should be noted here that the number of sessions between the first and the terminating session was not set in advance, but rather was naturally determined by the counselor(s) and the client. However, a client had to complete at least four therapy sessions before terminating in order to be administered any posttherapy instruments and thus be included in the data analysis. If a client did not complete at least four sessions, she was considered a "drop out." When a "drop out" occurred, the vacated space left by that client was immediately filled by a new client. This new client saw the same therapists that had previously been seeing the "drop out."[1]

After the terminating session the client was given a posttherapy Problems List, the Personal Orientation Inventory, a posttherapy Self-Actualization Scale, and the patient form of a Therapy Session Report. As with the first session, the terminating session was rated by outside judges on the scale of Helpee Self-Exploration. Every client,

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[1]There were seven cases in which clients terminated therapy before completing four sessions. In six of these cases, the client was in individual therapy, while in one case, the client was in multiple therapy. A sign test determined the probability of this occurrence as being .062.

regardless of the therapy condition she was in (e.g. multiple versus individual therapy) was given the same posttherapy instruments.

Therapists

After a prospective therapist had agreed to participate in the study, he or she was given the Myers-Briggs Type Indicator (Myers, 1958) if this had not previously been taken, and the Personal Orientation Inventory (Shostrom, 1966b). (For a description and discussion of these instruments and all other therapists instruments mentioned below, please see Kosch-Graham, 1972.) When the therapist had completed these two instruments, he or she was ready to be assigned a client. Each of the twelve therapists, regardless of sex or level of experience, saw one client in individual therapy and two clients in multiple therapy. In the multiple therapy condition, a therapist saw each of the two clients assigned to him with the same opposite-sexed co-therapist. The fact that each therapist saw one client individually and two clients in multiple therapy, allowed for an equal number of clients (twelve) to be seen in each condition.

The therapists involved in the study provided their own matched control, in that they participated in both the individual and multiple therapy conditions.

When therapists were in the individual therapy condition, and had completed their first session with a client,

they filled out the therapist form of the Therapy Session Report (Orlinsky and Howard, 1966b). When therapy with the client had terminated, the therapist again filled out a Therapy Session Report.

When the therapists were in the multiple therapy condition, both therapists separately filled out the Therapy Session Report after the first session with a client. The TSR was again filled out by both therapists after the terminating interview with a client. When doing multiple therapy, each of the two therapists of a team also filled out the Multiple Therapy Rating Scale (MTRS, Reiner and Kosch-Graham, 1972) and the Caring Relationship Inventory (CRI, Shostrom, 1966a) after the first session with the first client the pair was to see. Both of these instruments (e.g. CRI and MTRS) were designed to elicit information concerning the relationship between the two multiple therapists and their perceptions of each other. The CRI and the MTRS were also filled out by both therapists after completing the terminating session with the second client the team had seen.

When a therapist had completed his or her participation in the project (had seen one completed case in individual therapy and two completed cases in multiple therapy) he or she filled out a POI and the Comparative Therapy Scale (Rabin, 1967). The Comparative Therapy Scale was utilized to elicit the therapist's attitudes concerning multiple versus individual therapy.

When all the therapists had completed therapy with all the clients involved in the project, two trained judges rated the first and last sessions of each client on the Carkhuff (1969) scales of therapist empathy, respect, genuineness, and concreteness.

Hypotheses

The hypotheses that will be considered in this study have been divided into three major categories. These categories concern the efficacy of multiple versus individual therapy, client feelings, attitudes, and behavior in both treatment conditions, and finally client discussion in multiple and individual therapy. The data that were used to test these hypotheses came from five different psychotherapy instruments. These were the Personal Orientation Inventory (POI), the patient form of the Therapy Session Report (TSR), the Self-Actualization Scale (SAS), the Problems List, and the scale of Helpee Self-Exploration. Following each sub-hypothesis in a major category there is, in parentheses, the scale that was used in the testing of that sub-hypothesis.

One of the ways we have operationally defined efficaciousness with regard to client therapeutic outcome is the extent to which a client demonstrates greater self-actualization as a result of being in therapy. We have decided to use self-actualization as one of our operational definitions of

efficaciousness, since many researchers have felt that a more self-actualized or actualizing person might be seen as the end product of the process of therapy (Rogers, 1961; Shostrom, 1964; Maslow, 1970).

Although Maslow, Shostrom, and Rogers have all given similar definitions of self-actualization (Rogers does not use this exact term), we have decided to use the definition of self-actualization given by Maslow (1970):

> It [self-actualization] refers to man's desire for self-fulfillment, namely, to the tendency for him to become actualized in what he is potentially. This tendency might be phrased as the desire to become more and more what one idiosyncratically is, to become everything that one is capable of becoming (p. 46).

Maslow has also observed that self-actualized and actualizing people demonstrate certain characteristics. For example, these people have more efficient perceptions of reality and are more comfortable in their relations with reality. They are also more spontaneous, more accepting of themselves and others, more autonomous, have deeper and more profound interpersonal relationships, and show more creativity.

We have depended primarily on Shostrom's POI to measure changes in client self-actualization. Shostrom has generally taken Maslow's definition and characteristics of the self-actualized person and adapted them so that their presence, and possible development as a result of therapy, could be tested through the use of a self-administered inventory.

It is hypothesized that:

I. Multiple therapy is a more effective technique with regard to client therapeutic outcome than is individual therapy.

   A. Clients in multiple therapy will become relatively more independent and self-supportive than will clients in individual therapy (Scale I-POI).

   B. Clients in multiple therapy will become relatively more able to live in the present than will clients in individual therapy (Scale Tc-POI).

   C. Clients in multiple therapy will become relatively more able to accept aggression in themselves than will clients in individual therapy (Scale A-POI).

   D. Clients in multiple therapy will become relatively more able to accept themselves than will clients in individual therapy (Scale Sa-POI).

   E. Clients in multiple therapy will develop a relatively greater capacity for intimate contact than will clients in individual therapy (Scale C-POI).

   F. Clients in multiple therapy will become able to hold relatively more values of self-actualizing people than will clients in individual therapy (Scale SAV-POI).

   G. At termination, clients in multiple therapy will be more self-actualized than will clients in individual therapy (Self-Actualization Scale).

H. Clients in multiple therapy will have a greater resolution of personal problems than will clients in individual therapy (Problems List).

I. Clients in multiple therapy will report a more positive state of emotional and psychological well-being than will clients in individual therapy (Question #24-TSR).

J. The duration of therapy itself will be shorter for clients in multiple therapy than for clients in individual therapy.

II. Clients in multiple therapy will demonstrate more positive attitudes, feelings, and behavior toward the therapists and the therapy sessions themselves than will clients in individual therapy.

A. Clients in multiple therapy will feel that therapy sessions were more successful than will clients in individual therapy (Question #1-TSR).

B. Clients in multiple therapy will feel that they got more out of their therapy sessions than will clients in individual therapy (Questions #26-38-TSR).

C. Clients in multiple therapy will feel that they made more progress in dealing with their problems in therapy sessions than will clients in individual therapy (Question #23-TSR).

D. Clients in multiple therapy will be more friendly or respectful towards their therapists than will clients in individual therapy (Question #17-TSR).

E. Clients in multiple therapy will feel that their therapists were more warm and friendly toward them than will clients in individual therapy (Question #44-TSR).

F. Clients in multiple therapy will feel that their therapists were more helpful than will clients in individual therapy (Question #40-TSR).

G. Clients in multiple therapy will feel that their therapists understood their feelings and thoughts better than will clients in individual therapy (Question #39-TSR).

Two exceptions to the general statement of Hypothesis II are found in Hypothesis III.

III. Clients in multiple therapy will demonstrate more negative attitudes, feelings and behavior toward their therapist(s) than will clients in individual therapy.

A. Clients in multiple therapy will be more negative or critical towards their therapists than will clients in individual therapy (Question #19-TSR).

B. Clients in multiple therapy will feel that their therapists are more negative or critical towards them than will clients in individual therapy (Question #43-TSR).

IV. Client discussion will be different in multiple therapy than it is in individual therapy.

A. Clients will discuss a greater variety of interpersonal topics in multiple therapy sessions than in individual therapy sessions (Question $\#2_{1-4}$-TSR).

B. Clients will have more discussion of male-female roles in multiple therapy sessions than in individual therapy sessions (Question $\#2_2$-TSR).

C. There will be more client discussion of feelings or attitudes toward the therapist(s) in multiple therapy sessions than in individual therapy sessions (Question $\#2_4$-TSR).

D. Clients will demonstrate more self-exploration in multiple therapy than in individual therapy (Scale of Helpee Self-Exploration).

Statistical Treatment

Various statistical measures were used in order to test the hypotheses that have been presented. Hypotheses IA through IF concerned data gathered from the Personal Orientation Inventory. These hypotheses were tested through the use of two-way analyses of variance with repeated measures on one factor. The repeated measure factor was time (e.g. pretherapy versus posttherapy). The other factor was

treatment (e.g. individual therapy versus multiple therapy). F ratios from these two-way analyses of variance were considered to be significant when the corresponding p value was at .05 or less.

Hypothesis II, Hypotheses IIA through IIG, Hypotheses IIIA and IIIB, and Hypotheses IVA through IVC all concerned data from the Therapy Session Report; while Hypothesis IVD concerned data from the scale of Helpee Self-Exploration. All of these hypotheses were tested through the use of two-way analyses of variance with repeated measures on one factor. The repeated measure factor was time (e.g. post first session versus post termination session). The other factor here was treatment (e.g. individual therapy versus multiple therapy). The resulting F ratios from these two-way analyses of variance were considered to be significant when the corresponding p value was at .05 or less.

One-tailed t tests for independent samples were used both in the testing of Hypothesis IG (concerned data from the posttherapy SAS) and Hypothesis IJ (data concerning duration of therapy in both treatment groups). The significance level for these t tests was set at .05. Finally, a one-tailed t test for unequal variances (Hays, 1963) was used to analyze data from the Problems List (Hypothesis IH). The significance level for this t test was also set at .05.

With the exception of the Personal Orientation Inventory, the data from the full sample of 24 clients were used

in carrying out these various statistical tests. However, in the case of the POI, the sample size of 22 clients was used for the two-way analyses of variance. This reduced sample size was caused by the fact that one client in the individual condition misscored her POI and was dropped from the sample. This in turn necessitated the random dropping of one client from the multiple condition.

Pearson product-moment coefficients of correlation were used to determine judge reliability for the scale of Helpee Self-Exploration and for the Problems List.

RESULTS

The Efficacy of Multiple Versus Individual Therapy

The first set of hypotheses in this study concerns the efficacy of multiple versus individual therapy, and specifically hypothesizes that multiple therapy is a more effective technique than individual therapy with regard to client therapeutic outcome. The comparative efficacy of these two techniques will first be examined with regard to the data analyzed from client responses to the Personal Orientation Inventory.

Hypothesis IA predicted that clients in multiple therapy would become relatively more independent and self-supportive than would clients in individual therapy (Scale I-POI). This hypothesis predicts an interaction effect between the variables of treatment and time. As can be seen in Table 2, this interaction (F ratio = .9967; 1,20 df) is not significant. Looking at the main effects here, the F ratio for treatment (.0277; 1,20 df) is also nonsignificant. However, the variable of time (F ratio = 17.4300; 1,20 df) is significant at the .01 level. When this F ratio for time is looked at in conjunction with the means for POI Scale I (Table 2), it can be seen that regardless of the treatment

TABLE 2

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' PRE AND POST SCORES ON SCALE I OF THE POI IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
Pre	Post	Pre	Post
77.3636 (11.4129)	87.7272 (14.5746)	77.2727 (14.2484)	83.6363 (16.3173)

Source	df	MS	F
Between Subjects	21		
A (Treatment)	1	44.0833	.0277
Subjects within groups	20	1586.8416	
Within Subjects	22		
B (Time)	1	705.3333	17.4300**
AB	1	40.3334	.9967
B × Subjects within groups	20	40.4666	

Note: The standard deviations are in parentheses.

** $p < .01$

condition (be it multiple or individual therapy) clients became significantly more independent and self-supportive over the time that they were in therapy.

Hypothesis IB predicted that clients in multiple therapy would become relatively more able to live in the present than would clients in individual therapy (Scale Tc-POI). Again, an interaction effect between time and treatment is predicted. This interaction (F = .7415; 1,20 df) is not significant (Table 3). Although the factor of treatment (F ratio = .0575; 1,20 df) is also nonsignificant, the factor of time here (F ratio = 10.5353; 1,20 df) is again significant at greater than the .01 level. When we examine the above F ratios along with the means for POI Scale Tc (Table 3), the data can be interpreted as meaning that clients in the project, irrespective of treatment condition, became significantly more able to live in the present over the time that they were in therapy.

Hypotheses IC and ID predicted that clients in multiple therapy would become relatively more able to accept aggression and accept themselves than would clients in individual therapy (Scales A and Sa of the POI respectively). Both of these hypotheses predicted an interaction effect between treatment and time. The respective F ratios concerning these hypotheses (.9375; 1,20 df, and 1.1627; 1,20 df) are both nonsignificant (Tables 4 and 5). The main effect F ratios for treatment here (.0011; 1,20 df, and .4408; 1,20

TABLE 3

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' PRE AND POST SCORES ON SCALE Tc OF THE POI IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
Pre	Post	Pre	Post
13.4545 (3.4165)	16.2727 (3.2891)	13.4545 (2.5359)	15.0909 (4.8876)

Source	df	MS	F
Between Subjects	21		
A (Treatment)	1	3.5208	.0575
Subjects within groups	20	61.1479	
Within Subjects	22		
B (Time)	1	50.0208	10.5353**
AB	1	3.5209	.7415
B × Subjects within groups	20	4.7479	

Note: The standard deviations are in parentheses.

** $p < .01$

TABLE 4

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' PRE AND POST SCORES ON SCALE A OF THE POI IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
Pre	Post	Pre	Post
15.5454 (3.3575	16.6363 (4.0564)	15.0909 (3.5904)	17.2727 (4.1253)

Source	df	MS	F
Between Subjects	21		
A (Treatment)	1	.0833	.0011
Subjects within groups	20	73.4916	
Within Subjects	22		
B(Time)	1	27.0000	8.4375**
AB	1	3.0000	.9375
B × Subjects within groups	20	3.2000	

Note: The standard deviations are in parentheses.

** $p < .01$

TABLE 5

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' PRE AND POST SCORES ON SCALE Sa OF THE POI IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
Pre	Post	Pre	Post
14.0909 (3.3001)	17.0000 (3.2558)	13.3636 (3.3248)	14.4545 (3.7514)

Source	df	MS	F
Between Subjects	21		
A (Treatment)	1	27.0000	.4408
Subjects within groups	20	61.2500	
Within Subjects	22		
B(Time)	1	40.3333	5.6279*
AB	1	8.3333	1.1627
B x Subjects within groups	20	7.1666	

Note: The standard deviations are in parentheses.

* $p < .05$

df) are also nonsignificant. However, the main effect F ratios for the variable of time (8.4375; 1,20 df, and 5.6279; 1,20 df) are significant at greater than the .01 and .05 levels for the A and Sa scales respectively. The above F ratios along with the means for POI scales A and Sa (Tables 4 and 5) demonstrate that clients in the study (regardless of treatment condition) became significantly more able to accept aggression and accept themselves over the time that they were in therapy.

Hypothesis IE predicted that clients in multiple therapy would develop a relatively greater capacity for intimate contact than would clients in individual therapy (Scale C-POI). This predicted interaction effect between treatment and time (F ratio = .0026; 1,20 df) was nonsignificant (see Table 6). The main effect variable of treatment here (F ratio = .0061; 1,20 df) was also nonsignificant, while the main effect variable of time (F ratio = 6.6492; 1,20 df) proved to be significant at greater than the .05 level. When we examine these F ratios along with the means for POI Scale C (Table 6) it can be seen that clients (regardless of their treatment condition) developed a significantly greater capacity for intimate contact during the time that they were in therapy.

Finally, the last hypothesis that concerned data from the POI, Hypothesis IF, predicted that clients in multiple therapy would become able to hold relatively more values of

TABLE 6

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' PRE AND POST SCORES ON SCALE C OF THE POI IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
Pre	Post	Pre	Post
16.0909 (3.2697)	18.2727 (5.2553)	16.2727 (3.5239)	18.5454 (4.8242)

Source	df	MS	F
Between Subjects	21		
A (Treatment)	1	.5215	.0061
Subjects within groups	20	84.5479	
Within Subjects	22		
B (Time)	1	50.0215	6.6492*
AB	1	.0202	.0026
B × Subjects within groups	20	7.5229	

Note: The standard deviations are in parentheses.

* $p < .05$

self-actualizing people than would clients in individual therapy (Scale SAV-POI). The predicted interaction effect here (F ratio = .1840; 1,20 df) was nonsignificant (Table 7). The F ratio for the treatment main effect here (.2022; 1,20 df) was also nonsignificant. However, the main effect variable of time (F ratio = 4.6012; 1,20 df) was significant at greater than the .05 level. When these F ratios are examined in conjunction with the means for POI scale SAV (Table 7) it can be seen that clients in the study (regardless of treatment condition) became significantly more able to hold the values of self-actualizing people.

When all the hypotheses concerning the data from the POI (Hypotheses IA-IF) are examined together, it can be seen that the results are quite consistent. All the predicted interaction effects between treatment and time proved to be nonsignificant. Nonsignificance was also consistently found for the main effect variable of multiple versus individual therapy (treatment). The results were also consistent for the variable of time, in that regardless of the treatment condition or POI scale in question, clients demonstrated significantly positive changes from pre- to posttherapy on all the POI scales that were analyzed here.

Hypotheses IG through IJ concern the efficacy of the techniques of multiple and individual therapy with regard to analyzed data from the Self-Actualization Scale, the Problems List, the Therapy Session Report, and also with regard to

TABLE 7

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' PRE AND POST SCORES ON SCALE SAV OF THE POI IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
Pre	Post	Pre	Post
17.6363 (4.0068)	19.2727 (3.6903)	19.2727 (4.1010)	20.3636 (3.5290)

Source	df	MS	F
Between Subjects	21		
A (Treatment)	1	18.7500	.2022
Subjects within groups	20	92.7083	
Within Subjects	22		
B (Time)	1	18.7500	4.6012*
AB	1	.7500	.1840
B × Subjects within groups	20	4.0750	

Note: The standard deviations are in parentheses.

* $p < .05$

data concerning therapy duration for both treatment groups.

Hypothesis IG predicted that at termination clients in multiple therapy would be more self-actualized than would clients in individual therapy (Self-Actualization Scale). The result of the one-tailed t test for independent samples here ($t = -1.1239$; 11 df) was not significant (Table 8). Thus, at termination clients in multiple and individual therapy did not significantly differ from each other with regard to the amount of self-actualization they reported on the Self-Actualization Scale.

Hypothesis IH predicted that clients in multiple therapy would have a greater resolution of personal problems than would clients in individual therapy (Problems List). The one-tailed t test for unequal variances ($t = -1.9443$; 12 df) was significant at the .05 level (Table 9). However when this t is looked at in conjunction with the means for the two treatment groups (Table 9) it can be seen that a result occurred that was opposite to that predicted. That is, it was found that clients in individual therapy were judged to have had a greater resolution of personal problems than clients in multiple therapy.

Hypothesis I/I predicted that clients in multiple therapy would report a more positive state of emotional and psychological well-being than would clients in individual therapy (Question #24-TSR). The F ratio for the thus predicted treatment main effect (6.5280, 1,22 df) was significant

TABLE 8

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE 1-TAILED t TEST FOR THE CLIENTS' SCORES ON THE POSTTHERAPY SELF-ACTUALIZATION SCALE IN MULTIPLE AND INDIVIDUAL CONDITIONS

	Multiple	Individual
Mean	41.0000	47.0000
Standard Deviation	15.1712	9.1287

t	df
-1.1239	11

TABLE 9

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE 1-TAILED t TEST (UNEQUAL VARIANCES) FOR THE CLIENTS' RATINGS ON THE PROBLEMS LIST IN MULTIPLE AND INDIVIDUAL CONDITIONS

	Multiple	Individual
Mean	3.9722	4.6111
Standard Deviation	1.0585	.4225

t	df
-1.9443*	12

* $p < .05$

at the .05 level (Table 10). However, when the means for individual and multiple therapy are examined here (Table 10) it can be seen that once again a result opposite to that hypothesis was obtained. That is, it was found that clients in individual therapy reported a significantly more positive state of emotional and psychological well-being than clients in multiple therapy. Further examination of Table 10 reveals that the F ratio for the main effect of time (8.0481; 1,22 df) was significant at the .01 level, while the F ratio for the interaction between time and treatment (.0279; 1,22 df) was not significant.

Hypothesis IJ predicted that the duration of therapy itself would be shorter for clients in multiple therapy than for clients in individual therapy. A one-tailed t test for independent samples with the dependent variable being the number of sessions until termination was nonsignificant (t = .2247; 11 df, see Table 11). Thus, there was no significant difference in the number of sessions until termination for the clients in individual versus multiple therapy condition.

When we examined the data concerning the relative efficacy (with regard to client outcome) of the utilization of the therapeutic techniques of individual versus multiple therapy, we generally found that there were no significant differences between the therapeutic outcomes of the clients in the two groups. Two major exceptions to these findings

TABLE 10

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 24 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
3.3333 (1.0731)	4.0833 (.9003)	4.0833 (.9003)	4.7500 (.7538)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	6.0208	6.5280*
Subjects within groups	22	.9223	
Within Subjects	24		
B (Time)	1	6.0208	8.0481**
AB	1	.0209	.0279
B × Subjects within groups	22	.7481	

Note: The standard deviations are in parentheses.

* $p < .05$
** $p < .01$

TABLE 11

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE 1-TAILED t TEST CONCERNING THE DURATION OF THERAPY FOR CLIENTS IN MULTIPLE AND INDIVIDUAL CONDITIONS

	Multiple	Individual
Mean Number of Sessions	7.50	7.9166
Standard Deviation	3.1490	5.2830

t	df
-.2247	11

were the results for Question #24 of the Therapy Session Report and for the Problems List. In these cases, clients in individual therapy demonstrated both a more positive state of emotional and psychological well-being and a greater resolution of personal problems than did clients in multiple therapy. Both of these results were opposite to the predicted results. The implications of all of the above findings will be discussed in the next chapter.

Client Attitudes, Feelings, and Behavior in Multiple and Individual Therapy

The second set of hypotheses concerns the attitudes, feelings, and behavior that clients may have toward the treatment conditions of multiple and individual therapy, and toward the therapist(s) who worked with them in these two conditions. The specific major hypothesis here is that clients in multiple therapy will demonstrate more positive attitudes, feelings, and behavior toward the therapist(s) and the therapy sessions themselves than will clients in individual therapy.

The different attitudes, feelings, and behavior engendered by the above conditions will be examined through the use of data obtained from the patient form of the Therapy Session Report. Analysis of data for hypotheses concerning client attitudes and feelings toward the two types of therapy will first be presented (Hypotheses IIA- IIC). These

analyses will then be followed by the analyses of data for hypotheses concerning client attitudes, feelings, and behavior toward their therapist(s) (Hypotheses IIE-IIG).

Hypothesis IIA predicted that clients in multiple therapy would feel that therapy sessions were more successful than would clients in individual therapy (Question #1-TSR). The treatment main effect F ratio pertinent to this hypothesis (.1810; 1,22 df) was nonsignificant (see Table 12). This result can be interpreted as meaning that the treatment condition itself does not significantly affect how the client will feel about the success of a therapy session. The F ratios here for the main effect of time (1.5939; 1,22 df) and the interaction between time and treatment (.4919; 1,22 df) were also nonsignificant.

Hypothesis IIB states that clients in multiple therapy will feel that they got more out of their therapy sessions than will clients in individual therapy (Questions #26-38-TSR). The predicted main effect treatment F ratio (.9311; 1,22 df) was not significant (see Table 13). Thus, the fact that a client is in either multiple or individual therapy does not seem to significantly affect her feelings concerning what she got out of her therapy sessions. The F ratios for the main effect of time (1.5554; 1,22 df) and the interaction effect of time and treatment (.0001; 1,22 df) were not significant.

TABLE 12

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 1 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
4.2500 (.9653)	4.4166 (1.4434)	4.1666 (.7177)	4.7500 (1.1382)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.1875	.1810
Subjects within groups	22	1.0359	
Within Subjects	24		
B (Time)	1	1.6875	1.5939
AB	1	.5208	.4919
B x Subjects within groups	22	1.0587	

Note: The standard deviations are in parentheses.

TABLE 13

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEMS 26-38 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
11.8333 (5.1669)	15.9166 (6.4450)	10.1666 (4.2605)	14.1666 (5.7340)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	35.0208	.9311
Subjects within groups	22	37.6117	
Within Subjects	24		
B (Time)	1	196.0208	1.5554
AB	1	.0209	.0001
B X Subjects within groups	22	126.0208	

Note: The standard deviations are in parentheses.

The last hypothesis here concerning a client's feelings and attitudes toward the two types of therapy, Hypothesis IIC, predicted that clients in multiple therapy would feel that they made more progress in dealing with their problems in therapy sessions than would clients in individual therapy (Question #23-TSR). The F ratio pertinent to this hypothesis, the treatment main effect F ratio (.0143; 1,22 df) was not significant (Table 14). This result can be interpreted to mean that a client's presence in multiple versus individual therapy does not significantly affect her feelings concerning the amount of progress she feels she has made in dealing with her problems in therapy sessions. The F ratio for the main effect of time (6.6506; 1,22 df) was significant at the .05 level. When this result is looked at in conjunction with the means presented for Question #23 of the TSR (see Table 14) it can be seen that in general clients (regardless of their treatment condition) felt that they had made significantly more progress in dealing with their problems after the terminating session than after their first session of therapy. The F ratio here for the interaction between treatment and time (.0126; 1,22 df) was not significant.

When we examine the data concerning Hypotheses IIA-IIC, it can be seen that the treatment condition variable does not seem to significantly affect client feelings and attitudes concerning the success of, the progress made in, or

TABLE 14

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 23 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
3.3333 (1.3027)	4.2500 (1.4848)	3.3333 (.9847)	4.3333 (1.1547)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.0208	.0143
Subjects within groups	22	1.4450	
Within Subjects	24		
B (Time)	1	11.0208	6.6506*
AB	1	.0209	.0126
B × Subjects within groups	22	1.6571	

Note: The standard deviations are in parentheses.

* $p < .05$

what she got out of her therapy sessions.

Hypotheses IID-IIG concern the clients' attitudes, feelings, and behavior toward their therapist(s). Hypothesis IID predicted that clients in multiple therapy would be more friendly or respectful towards their therapists than would clients in individual therapy (Question #17-TSR). The predicted treatment main effect F ratio (.0420; 1,22 df) was not significant (Table 15). Thus, the variable of treatment condition does not significantly affect the clients' feelings of friendliness or respect toward their therapist(s). The main effect F ratio here for time (1.6470; 1,22 df) was also not significant, nor was the F ratio for the interaction between treatment and time (3.2286; 1,22 df).

Hypothesis IIE predicted that clients in multiple therapy would feel that their therapists were more warm and friendly toward them than would clients in individual therapy (Question #44-TSR). The predicted treatment main effect F ratio (.0633; 1,22 df) was not significant (see Table 16). This datum is interpreted as meaning that the variable of treatment condition does not significantly affect a client's feelings on the dimension of therapist(s) warmth or friendliness toward the client. The F ratios for the main effect of time (.2681; 1,22 df) and the interaction effect between treatment and time (.2685; 1,22 df) were also nonsignificant.

Hypothesis IIF stated that clients in multiple therapy would feel that their therapists were more helpful than

TABLE 15

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 17 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
2.2500 (.6216)	2.1666 (.7177)	1.9166 (.6686)	2.4166 (.5149)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.0208	.0420
Subjects within groups	22	.4950	
Within Subjects	24		
B (Time)	1	.5208	1.6470
AB	1	1.0209	3.2286
B x Subjects within groups	22	.3162	

Note: The standard deviations are in parentheses.

TABLE 16

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 44 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
2.0833 (.7930)	2.0833 (.9962)	1.9166 (.7930)	2.0833 (.9962)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.0833	.0633
Subjects within groups	22	1.3143	
Within Subjects	24		
B (Time)	1	.0833	.2681
AB	1	.0834	.2685
B × Subjects within groups	22	.3106	

Note: The standard deviations are in parentheses.

would clients in individual therapy (Question #40-TSR). A treatment main effect was therefore predicted. The F ratio for this main effect (.6929; 1,22 df) was not significant (Table 17). Thus, the treatment condition did not significantly affect the client's feelings about how helpful she considered her therapist(s) to be. Again, the F ratios for the main effect of time (2.3856; 1,22 df) and for the interaction effect between time and treatment (.2650; 1,22 df) were also nonsignificant.

Hypothesis IIG predicted that clients in multiple therapy would feel that their therapists understood their feelings and thoughts better than would clients in individual therapy (Question #39-TSR). The predicted treatment main effect F ratio (.6823; 1,22 df) was not significant (see Table 18). There appears then to be no significant difference between the two treatment groups on the dimension of how well clients felt that their therapist(s) understood their feelings and thoughts. The F ratios here for the time effect (.6558; 1,22 df) and for the interaction effect between treatment and time (.0727; 1,22 df) were also not significant.

The results for this second set of hypotheses are very consistent. Analysis of the TSR questions pertinent to these seven hypotheses reveals that the treatment condition a client is placed in (either individual or multiple therapy) does not significantly affect (on a positive dimension) her

TABLE 17

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 40 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
3.6666 (1.2309)	4.3333 (1.5570)	4.1666 (1.0299)	4.5000 (1.1677)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	1.3333	.6929
Subjects within groups	22	1.9242	
Within Subjects	24		
B (Time)	1	3.0000	2.3856
AB	1	.3333	.2650
B × Subjects within groups	22	1.2575	

Note: The standard deviations are in parentheses.

TABLE 18

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 39 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
3.4166 (.5149)	3.5000 (1.0000)	3.5833 (.5149)	3.7500 (.7538)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.5208	.6823
Subjects within groups	22	.7632	
Within Subjects	24		
B (Time)	1	.1875	.6558
AB	1	.0208	.0727
BX Subjects within groups	22	.2859	

Note: The standard deviations are in parentheses.

feelings, attitudes, or behavior either with regard to the therapist(s) that is/are treating her or toward the therapy sessions themselves. We have also found that for the most part, the variable of time and the interaction between time and treatment are also not significantly influential in affecting the client's attitudes, feelings, and behavior with regard to the therapist(s) or the therapy sessions.

Negative Feelings of the Client in Multiple and Individual Therapy

The third set of hypotheses again concerns the client's feelings about her therapist(s), and specifically states that clients in multiple therapy will demonstrate more negative attitudes, feelings, and behavior toward their therapists than will clients in individual therapy. Two subhypotheses concerning these client attitudes, feelings, and behaviors will be examined through the use of data from the patient form of the Therapy Session Report.

Hypothesis IIIA predicts that clients in multiple therapy will be more negative or critical towards their therapists than will clients in individual therapy (Question #19-TSR). The predicted treatment main effect F ratio (2.9024; 1,22 df) is not significant (Table 19). Thus, the treatment condition that a client is in does not significantly affect the amount of negativeness or criticalness that is shown towards the therapist(s). The F ratio here for the main

TABLE 19

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 19 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
.3333 (.4924)	.7500 (1.0553)	.0833 (.2877)	.2500 (.2877)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	1.6875	2.9024
Subjects within groups	22	.5814	
Within Subjects	24		
B (Time)	1	1.0208	4.3044*
AB	1	.1875	.7796
B x Subjects within groups	22	.2405	

Note: The standard deviations are in parentheses.

* $p < .05$

effect of time (4.3044; 1,22 df) is significant at the .05 level. When this result is examined in conjunction with the means for Question #19 (see Table 19) it can be seen that clients (regardless of their treatment condition) were significantly more negative or critical towards their therapist(s) in the terminating session than they were in the first session. The F ratio here for the interaction effect between time and treatment (.7796; 1,22 df) is not significant.

Hypothesis IIIB states that clients in multiple therapy will feel that their therapists are more negative or critical towards then than will clients in individual therapy (Question #43-TSR). The predicted treatment main effect F ratio here (8.2116; 1,22 df) was significant at the .01 level (Table 20). Thus, clients in multiple therapy viewed their therapists as significantly more negative or critical towards them than did clients in individual therapy. The F ratios here for the main effect of time (.5116; 1,22 df) and for the interaction effect between time and treatment (2.0479; 1,22 df) were not significant.

Client Discussion in Multiple and Individual Therapy

The fourth and final set of hypotheses concern client discussion in multiple and individual therapy. The major hypothesis here states that client discussion will be different in multiple therapy than it is in individual therapy.

TABLE 20

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 43 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
.5000 (.5222)	.7500 (.4523)	.2500 (.4523)	.1666 (.3829)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	2.0833	8.2116**
Subjects within groups	22	.2537	
Within Subjects	24		
B (Time)	1	.0833	.5116
AB	1	.3334	2.0479
B × Subjects within groups	22	.1628	

Note: The standard deviations are in parentheses.

** $p < .01$

The data for these hypotheses came from the patient form of the TSR and from the Scale of Helpee Self-Exploration in Interpersonal Processes.

Hypothesis IVA states that clients will discuss a greater variety of interpersonal topics in multiple therapy sessions than in individual therapy sessions (Questions $\#2_{1-4}$-TSR). The hypothesis predicts a treatment main effect. The F ratio for this treatment main effect (.0158; 1,22 df) is not significant (Table 21). Thus, clients in multiple therapy do not discuss a significantly greater variety of topics than clients in individual therapy. The time main effect F ratio (.7256; 1,22 df) was not significant. A non-significant F ratio (.2615; 1,22 df) was also found for the interaction effect between time and treatment.

Hypothesis IVB predicted that clients would have more discussion of male-female roles in multiple therapy sessions than in individual therapy sessions (Question $\#2_2$-TSR). The F ratio for the predicted treatment main effect (.7587; 1,22 df) was not significant (Table 22). Thus, clients in multiple therapy did not have significantly more discussion of male-female roles than clients in individual therapy. The F ratios for the main effect of time (.0000; 1,22 df) and for the interaction effect between time and treatment (3.0350; 1,22 df) were also not significant.

Hypothesis IVC states that there will be more client discussion of feelings or attitudes towards the therapist(s)

TABLE 21

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 2_{1-4} IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
2.8333 (.8348)	2.7500 (.9653)	3.0000 (1.0445)	2.6666 (1.1547)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.0208	.0158
Subjects within groups	22	1.3087	
Within Subjects	24		
B (Time)	1	.5208	.7256
AB	1	.1877	.2615
Bx Subjects within groups	22	.7177	

Note: The standard deviations are in parentheses.

TABLE 22

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 2_2 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
1.1666 (.5774)	1.5000 (.6742)	1.3333 (.6513)	1.0000 (.7385)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.3333	.7587
Subjects within groups	22	.4393	
Within Subjects	24		
B (Time)	1	.0000	.0000
AB	1	1.3333	3.0350
Bx Subjects within groups	22	.4393	

Note: The standard deviations are in parentheses.

in multiple therapy sessions than in individual therapy sessions (Question #2_4-TSR). The F ratio for the treatment main effect (.1325; 1,22 df) was not significant (Table 23). Thus, the treatment group of a client does not seem to significantly affect client discussion of feelings or attitudes toward the therapist(s). The F ratios for the main effect of time (.9566; 1,22 df) and for the interaction effect between time and treatment (.0002; 1,22 df) were also not significant.

Finally, Hypothesis IVD predicted that clients would demonstrate more self-exploration in multiple therapy than in individual therapy (scale of Helpee Self-Exploration). Thus, a treatment main effect was predicted. The F ratio for the main effect of treatment (2.6960; 1,22 df) was nonsignificant (Table 24). Also nonsignificant here were the F ratios for the main effect variable of time (.2410; 1,22 df) and for the interaction effect between treatment and time (2.5105; 1,22 df).

Upon examining the data concerning Hypotheses IVA-IVD, we find that the variable of treatment condition does not significantly affect client discussion in therapy sessions. This was a consistent finding throughout the four relevant hypotheses. We have also found here that the variable of time and the interaction between time and treatment are also not significantly influential with regard to their effect on client discussion in therapy sessions.

TABLE 23

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO TSR ITEM 2_4 IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
.6666 (.4924)	.8333 (.5774)	.7500 (.6216)	.9166 (1.0836)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.0833	.1325
Subjects within groups	22	.6287	
Within Subjects	24		
B (Time)	1	.3333	.9566
AB	1	.0001	.0002
BX Subjects within groups	22	.3484	

Note: The standard deviations are in parentheses.

TABLE 24

SUMMARY TABLE OF MEANS, STANDARD DEVIATIONS, AND THE ANALYSIS OF VARIANCE FOR THE CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY SELF-EXPLORATION RATINGS IN MULTIPLE AND INDIVIDUAL CONDITIONS

Multiple		Individual	
After 1st Session	Posttherapy	After 1st Session	Posttherapy
2.8055 (.3945)	2.6076 (.3884)	2.9166 (.5105)	3.0208 (.4197)

Source	df	MS	F
Between Subjects	23		
A (Treatment)	1	.7975	2.6960
Subjects within groups	22	.2958	
Within Subjects	24		
B (Time)	1	.0263	.2410
AB	1	.2739	2.5105
B x Subjects within groups	22	.1091	

Note: The standard deviations are in parentheses.

DISCUSSION

The purpose of this study was to compare the therapeutic treatment conditions of multiple and individual therapy. Comparisons between these two types of therapy were made on three major dimensions. First, multiple therapy was compared to individual therapy with regard to the two techniques' effectiveness in leading to favorable client therapeutic outcomes. Second, client feelings, attitudes, and behavior toward the two treatment conditions and the therapists were compared. Finally, a comparison was made between client discussion in multiple and individual therapy. This chapter will discuss these comparisons in relation to the statistical analyses presented in the previous chapter. Specifically, these previously presented findings, and the implications and speculations that can be made from them, will be discussed in relation to both the relevant hypotheses of the study and the literature in the field of multiple therapy. Suggestions for future research will also be made here. This discussion will draw in part upon some of the findings obtained by this author's co-researcher in her study of the twelve therapists that were involved in the project (Kosch-Graham, 1972).

The Effectiveness of Multiple Versus Individual Therapy

In the field of multiple therapy, there have been many researchers who have concerned themselves with the efficacy of this technique. Beginning with the work of Adler (1930), Reeve (1939), Whitaker, Warkentin and Johnson (1949), Dreikurs (1952), and continuing into the present day literature (Mintz, 1965; Kell and Burow, 1970), it can be seen that researchers who have examined this technique have, but with few exceptions, endorsed the use of multiple therapy as a technique that is more advantageous than the use of one therapist alone; especially with regard to the patient's progress and/or eventual outcome in therapy. For example, there is the statement by Whitaker et al. (1956) that multiple therapy "has been a more effective form of treatment with all patients than individual therapy" (p. 211). Thus, there is substantial backing in the literature for the hypothesis that multiple therapy is a more effective technique than individual therapy with regard to client therapeutic outcome.

One way of defining such effectiveness is the extent to which a client becomes more self-actualized as a result of the application of the technique. Writers such as Rogers (1961), Shostrom (1964), and Maslow (1970), have all suggested that increased self-actualization might be seen as an end product or goal of the process of psychotherapy.

For example, Maslow (1970) writes "...the ultimate positive goal of all therapy, [is] namely, self-actualization" (p. 178).

Using both the above reasoning and specific observations from the literature on multiple therapy, it was predicted that in the present study, clients in multiple therapy would become relatively more self-actualized (as measured by a variety of scales) than clients in individual therapy. However, when the findings of this study concerning client self-actualization were examined, it was found that multiple therapy clients did not show greater increases in self-actualization than clients in individual therapy. According to the Self-Actualization Scale, at termination clients in multiple therapy were not more self-actualized than clients in individual therapy (Hypothesis IG). Using other scales of self-actualization, it was also found that clients in multiple therapy did not become relatively more independent and self-supportive, nor relatively more able to live in the present, nor able to hold relatively more values of self-actualizing people than clients in individual therapy (Hypotheses IA, IB, and IF respectively).

Another aspect of self-actualization tested in the present study concerned the clients' ability to accept aggressive feelings within herself. If one follows the reasoning that the comparatively greater effectiveness of a technique will be reflected by greater self-actualization, one

would expect that multiple therapy clients, as compared to individual therapy clients, would become more able to accept aggression within themselves (Hypothesis IC). However, no difference was demonstrated between the two treatment groups on this dimension of self-actualization. This finding is interesting and nonsupportive of Greenback's (1964) belief that rage or aggressive transferential feelings are more acceptable to the patient when there is more than one therapist to accept these feelings. Such a finding also does not lend support to the observation of Hayward et al. (1952), that as a result of more than one therapist being present, a multiple therapy client will feel less guilty (and by implication, more accepting) of his aggressive or hostile feelings.

One of the advantages of multiple therapy that is sometimes cited in the literature is that clients in this treatment condition can become more able to accept themselves. Warkentin et al. (1951) observed that many patients in treatment with more than one therapist experienced therapy as an almost cultural acceptance--as if the whole world was with them. One would expect that such a feeling of cultural acceptance would easily create within a patient an experience of greater self-acceptance. Nunnelly (1970) also found that the use of two therapists produces greater self-acceptance among clients than the use of one therapist. (It should also be noted that the trait of self-acceptance is considered

by many writers such as Maslow and Shostrom to be an important aspect of self-actualization.) Thus, for various reasons it was predicted that clients in multiple therapy would become more self-accepting than individual therapy clients (Hypothesis ID). However, this study revealed no significant differences between these two groups on the dimension of self-acceptance. One possible explanation for this finding might be that clients in multiple therapy did not experience the feeling of cultural acceptance from their therapists. This seems plausible, since we do know that the clients in multiple therapy, as compared to individual therapy clients, rated their therapists as being significantly more negative or critical towards them (see Table 20, Results).

Another self-actualizing trait that was considered here was the ability of a client to develop a relatively greater capacity for intimate contact or warm interpersonal relationships in the two treatment conditions. The present study did not find that clients in multiple therapy developed a relatively greater capacity for intimate contact than clients in individual therapy (Hypothesis IE). This finding is unexpected, in that many researchers (Singer and Fisher, 1967; Linden et al., 1968, etc.) have implied that one of the advantages of multiple therapy is that through having the opportunity to observe a warm and healthy relationship between two therapists, clients here would in turn be

encouraged to have such relationships in their own personal lives. If such a process had occurred, one would expect that multiple therapy clients would have developed a greater capacity for intimate contact than clients in individual therapy. Since such a finding was not obtained, one could hypothesize that the finding of no difference between the two treatment groups was due to poor or even mediocre relationships between the therapists on the various multiple therapy teams. However, this explanation seems doubtful, since Kosch-Graham (1972) found that these co-therapists developed quite caring and healthy relationships over the time that they were working together. Perhaps then, just the act of observing a healthy and caring relationship between two therapists is not sufficiently influential in bringing about greater changes in the capacity for intimate contact in multiple therapy than in individual therapy.

Thus, the concept that multiple therapy is a more effective technique than individual therapy, and that this effectiveness would in turn be demonstrated by greater developing self-actualization on the part of multiple therapy clients, is not at all supported by the above findings. Similarly, other theories and observations concerning the advantageousness of multiple therapy for producing certain results (namely, greater changes in certain traits we have termed as self-actualizing) have also not been supported.

However, it is important to note that the above findings should not be construed as implying that multiple therapy is ineffective in bringing about significantly positive changes in client self-actualization. Although the treatment condition a client was in did not seem to be an influential factor in contributing to a significant increment in self-actualization, it was found that both treatment groups significantly improved over time in therapy on six different POI scales of self-actualization. As there was no non-therapy control group, these findings cannot be considered as conclusive. However, we can at least seriously postulate that multiple therapy as well as individual therapy can be effective in helping a client to become a more self-actualized individual.

Contrary to claims in the multiple therapy literature, data from two therapy measures demonstrated that individual therapy was significantly more effective than multiple therapy in producing favorable client outcomes. It was found at termination that clients in individual therapy were judged as showing significantly greater resolution of their personal problems than clients in multiple therapy (Hypothesis IH). It was also found that while in treatment, clients in individual therapy reported a significantly more positive state of emotional and psychological well-being (on a TSR scale) than clients in multiple therapy (Hypothesis I/I). Since a large number of hypotheses were tested in this study,

with only a few showing significant differences between the two treatment groups, these significant findings could be attributed to chance. However, it should also be noted that there was no finding in the entire study that showed multiple therapy as being more successful than individual therapy.

The findings from the Problems List are quite surprising in light of the fact that many of the problems listed by the client population seemed especially well-suited for treatment in the multiple therapy modality. For example, 38% of all clients listed as a major problem their relationship with their parents, while 42% of all the clients listed their relationship with a boy or boys as a major problem. Some other problems listed by the client population were: problems expressing feelings (33%), feelings of insecurity (21%), problems relating to a friend (17%), problems relating to a sibling (8%), and depression (8%). Most of the problems were quite evenly distributed over clients in the individual and multiple conditions.

The final measure of therapeutic effectiveness with regard to client outcome was a comparison of the duration of therapy for the two treatment groups. Researchers such as Whitaker et al. (1956) and Hayward et al. (1952) have stated that one of the advantages of multiple therapy is that treatment time here is shorter than with other forms of therapy. The observations of these researchers were not supported by the data in the present study, since in this project the two

treatment groups did not significantly differ on the number of therapy sessions until termination (Hypothesis IJ). This finding lends strong support to the criticism that the multiple therapy technique is too expensive, both in terms of cost to the patient and manpower being employed, to justify its implementation (Dyrud and Rioch, 1953; Greenback, 1964; MacLennan, 1965).

When all of the above findings are considered, we find that the many claims for the greater effectiveness of multiple therapy are not supported. Perhaps even more importantly, we have found that on two psychotherapy measures, clients in individual therapy actually demonstrated a more favorable outcome. The criticisms of multiple therapy that question its implementation because of its expense would certainly seem valid for those findings in the present study that showed no differences between the two treatment groups. However, we must even more seriously question the justification of implementing multiple therapy when we discover data that demonstrate that individual therapy can produce more favorable client outcomes than multiple therapy.

Client Attitudes

Client Attitudes Toward the Treatment Conditions

As we have shown previously, the literature is replete with general claims concerning the efficaciousness of multiple therapy over other forms of treatment. Various reasons for

the success of multiple therapy have been given. Some researchers believe that the greater effectiveness of multiple therapy is due to the simulated family triad produced here, which allows patients to more quickly and more effectively recreate and work through early prominent conflicts (Dreikurs et al. 1952b; Kell and Burow, 1970). Other reported advantages of this technique are: (1) therapeutic impasses are more readily avoided or more readily dissolved when they do occur; and (2) the client can view himself as being more important and accepted. (See Chapter I for references to these and other advantages.) These purported advantages are especially important in view of the fact that it was hypothesized that such advantages of multiple therapy would be reflected by multiple therapy clients having more positive attitudes concerning their treatment condition than clients in individual therapy.

When we examined client attitudes of positivity towards their treatment conditions, we found that clients in multiple therapy did not feel they made more progress in therapy or that they got more out of their therapy sessions than did clients in individual therapy (Hypotheses IIC and IIB respectively). Multiple therapy clients also did not rate their therapy sessions as being more successful than did clients in individual therapy (Hypothesis IIA). These findings imply that the purported advantages of multiple therapy are not so effective that they will result in multiple

therapy clients having more positive attitudes about their treatment than individual therapy clients. Perhaps the re-creation of early prominent conflicts through a simulated family triad is not always significantly influential. However, these findings may also be a result of some of the limitations of this study. The results might have been different, for example, if the therapists in this project had had more experience with multiple therapy. This limitation and certain others will be discussed in a later section.

Client Attitudes Toward Their Therapist(s)

There are some purported advantages of multiple therapy that seem capable of directly affecting multiple therapy clients' attitudes toward the therapists. For example, Warkentin et al. (1951) believe that one such advantage here is that there is increased responsiveness to the patient, since there is a greater chance that at least one therapist will hear a statement made by a client. Another of these advantages is cited by Dreikurs (1950), who thinks that the use of two therapists with different personalities allows the therapists to complement and supplement each others' traits and abilities in the treatment of the client. A third advantage in this area was mentioned by Dreikurs et al. (1952a), who believe that the use of two therapists increases the accuracy of diagnosis and interpretation. One might predict that such complementation and supplementation between therapists, along with the therapists' increased

responsiveness and increased accuracy of diagnosis and interpretation, might create within multiple therapy clients, as compared to individual therapy clients, a feeling that their therapists were more helpful (Hypothesis IIF) and more understanding of their feelings and thoughts (Hypothesis IIG). However, neither of these hypotheses was supported. It is difficult to determine from the present data if such variables as complementation and supplementation between therapists, and therapist increased responsiveness are related to multiple therapy clients' perceptions of being understood and feeling that their therapists were helpful. However, if these variables are related, one might speculate that because the therapist pairs had had no previous experience in working together, such therapist team traits as complementation, supplementation, and increased responsiveness to the client might not have had the chance to fully develop.

The attitudes of the clients towards their therapists were also investigated along another dimension. Specifically we were interested in both the amount of friendliness or negativeness shown toward the therapist(s), and the clients' perceptions of friendliness or negativeness demonstrated by the therapists. It was felt that the investigation of positive and negative feelings and perceptions would give us some initial ideas concerning the differences and similarities of transference development in multiple and individual therapy.

Many researchers believe that one of the advantages of multiple therapy is that it speeds the development and working through of transferential feelings (Greenback, 1964; Dyrud and Rioch, 1953). Researchers in this area have also observed that the presence of two therapists can bring forth stronger and more varied transference reactions, since the patient can express positive and negative transference separately and simultaneously to the two therapists (Whitaker et al. 1956). Hayward et al. (1952) presented this idea quite succinctly: "When two or more physicians are present, the patient can split up his feelings so that strong affection is expressed for one physician and hostility for another" (p. 244). (This splitting of feelings referred to by Hayward et al. is sometimes termed "splitting the transference.") Mintz (1963b) also feels that the expression of negative transference is made easier by the fact that clients usually have positive feelings toward at least one therapist, which in turn gives them a feeling of "safe anchorage" from which to express negative feelings.

As a result of surveying these observations on transference in the multiple therapy literature it was predicted that clients in multiple therapy would feel that they were both more friendly and respectful (Hypothesis IID) and more negative or critical (Hypothesis IIIA) towards their therapists than would clients in individual therapy. Due to the projective aspects of transference, it was also predicted

that clients in multiple therapy would perceive their therapists as being more warm and friendly (Hypothesis IIE) and more negative or critical towards them (Hypothesis IIIB) than clients in individual therapy. There was no difference between the two groups with regard to client perceptions of how warm and friendly their therapist(s) were. However, clients in multiple therapy did perceive their therapists as being significantly more negative or critical towards them than did clients in individual therapy. Thus, Hypothesis IIIB was supported. Finally, it was also found that there was no more client discussion of feelings or attitudes towards the therapists in multiple therapy sessions than in individual therapy sessions (Hypothesis IVC).

If these findings concerning client discussion, feelings, and perceptions of the therapist(s) can be considered as related to transference development, it seems that for the most part there were no differences on this dimension between the two treatment groups. One possible explanation for these results might be found in the one exception to these findings. As previously noted, clients in multiple therapy perceived their therapists as being significantly more negative or critical towards them than did clients in individual therapy. Although this finding must be qualified (all the mean ratings on this TSR scale were less than one on a three point scale), it might still be hypothesized that such a perception, or transferential projection, on the part

of multiple therapy clients might have prevented them from developing more positive and negative feelings toward their therapists than clients in individual therapy. The above findings might also be a result of the relative shortness of the therapy cases in the present study (mean number of sessions for multiple and individual clients was 7.5 and 7.9 sessions respectively). With such brief courses of therapy, transference might not have had the chance to fully develop. Perhaps if the mean number of sessions had been a good deal higher in both conditions, multiple therapy clients might have ended up demonstrating stronger feelings and perceptions than individual therapy clients. It should be noted that the above findings could also have been due to the fact that clients here only rated their feelings and perceptions of the therapist(s) after the first and last sessions. Perhaps if there had also been ratings for the middle phases of therapy, we would have obtained a picture of transference development that was more supportive of our hypothesis here. Finally, these findings might have been due to the fact that the instrument used to investigate transference (Therapy Session Report) was certainly not designed to investigate this aspect of the therapeutic process. It is difficult to determine if by questioning a client's positive and negative feelings and perceptions concerning a therapist, we are in fact examining transferential patterns.

If we accept the possibility that a transference dimension was measured, then these findings contradict Slavson's (1960) belief that by "splitting the transference" in multiple therapy the transference is weakened.

It should also be noted that Kell and Burow (1970) have observed that multiple therapy as compared to other forms of therapy allows the therapists to be more affectively involved with the client. One would suspect that if there were greater affective involvement on the part of the multiple therapists, such involvement would affect the development of client transference on both the feeling and perceptive dimensions. However, the present study generally found no differences between the two treatment groups. Such findings might be interpreted as meaning that the multiple therapists did not take full advantage of their opportunity for affective involvement. Another possibility is that the multiple therapy condition does not allow the therapists to be more affectively involved. Although further research would be required to determine what factors are responsible for the degree of affective involvement in multiple therapy, we do know that the therapists here were no more affectively involved in the multiple condition than in the individual condition (Kosch-Graham, 1972).

Client Discussion in Multiple and Individual Therapy

It was predicted that client discussion in multiple therapy would be different than client discussion in individual therapy. For example, it was hypothesized that clients in multiple therapy would discuss a greater variety of interpersonal topics than clients in individual therapy (Hypothesis IVA). This hypothesis was based on the fact that certain researchers have observed some aspects of multiple therapy that would be expected to lead to a greater variety of interpersonal topics being discussed here. Dreikurs et al. (1952a) have observed that the addition of a second therapist will make it more likely that the patient will fully exhibit his disturbed relations with people. Demarest and Teichner (1954) observed that the use of two therapists of different sexes provides the patient with more material for working on present and past problem situations. Neither of the aforementioned observations was even indirectly supported by the present study, since clients here did not discuss differentially interpersonal topics in the two conditions.

In this project, clients in multiple therapy also did not have more discussion of male and female roles than clients in individual therapy (Hypothesis IVB). Such a finding is somewhat surprising in light of the observation by Mullan and Sanguiliano (1960) that the use of two opposite-sexed therapists can bring forth and challenge more

quickly all the clients' stereotypes concerning male and female roles.

In the literature concerning client self-exploration, there is the finding that self-exploration is significantly and positively related to client outcome (Truax and Carkhuff, 1967). Since much of the literature on multiple therapy implies that the implementation of this technique will bring about a more favorable outcome, it was predicted that there would be more self-exploration in multiple therapy than in individual therapy (Hypothesis IVD). It has also been found that self-exploration is positively related to the therapist levels of empathy, respect, genuineness, and concreteness. Thus, the finding of no difference between the two treatment groups on self-exploration is unexpected, since Kosch-Graham (1972) found that in the individual condition, therapists here demonstrated significantly higher levels of these conditions in the last session than in the first session, while in multiple therapy, the level of therapist conditions did not change over time. This significant and positive change by the therapists in individual therapy was obviously not enough to affect client self-exploration.

General Explanations

The findings that have been presented concerning the outcome, attitudes, and discussion of clients in multiple and individual therapy are notably quite consistent in that

they generally lend no support to the numerous claims found in the literature for the greater effectiveness of multiple therapy over other forms of treatment. One possible explanation for this variance is that most of the literatures' claims have been based on general clinical observations (i.e. Dreikurs et al. 1952b; Mintz, 1965; Kell and Burow, 1970), rather than on well-developed and designed research projects that offer statistical documentation to substantiate endorsements for the effectiveness of multiple therapy. It is a fair supposition that these general observations might be biased by the personal attitudes of the observer. When past research on the attitudes of therapists toward individual and multiple therapy is examined, it can be seen that therapists rating the two treatment modalities in the abstract prefer multiple therapy to individual therapy. It was found that these same samples of therapists also felt that multiple therapy was the more effective treatment modality (Rabin, 1967; Kosch-Graham, 1972). Thus, it is possible that many of these endorsing past researchers might have had biased observations that resulted from their positive attitudes toward multiple therapy.

Another possible explanation for the variance between the claims in the literature and the findings in the present study is that although many studies cite the advantages of multiple therapy over other forms of treatment, very few studies have actually presented test comparisons between

multiple therapy and another type of treatment. The study by Mallars (1968) was one of the only projects surveyed that actually compared multiple therapy with one patient to individual therapy. Thus, many of the endorsements for the greater efficacy of multiple therapy could be erroneous simply due to the fact that they were not based on systematic and scientific comparisons between multiple therapy and other forms of treatment. If the variance between the findings of the present study and the efficacy claims in the literature can be attributed to the lack of previous comparative studies or to possible personal bias of the clinical observers here, then some of the specific theories concerning multiple therapy must be re-examined.

One theory for the greater effectiveness of multiple therapy that has been discussed at length in this thesis can be termed the transference theory. Various researchers have postulated that multiple therapy, with its inherent advantage of creating a simulated family triad, will bring about a stronger and more easily developed transference for the clients involved in this treatment modality. It is also believed by many, that as a result of the client experiencing and working on this quickly developed transference, there will be a more favorable and rapid outcome. The present study did not generally find that clients in multiple therapy developed stronger transferential feelings and perceptions toward their therapists than clients in individual

therapy. Multiple therapy clients also did not have a more favorable or rapid outcome than clients in individual therapy. Possible explanations for the findings concerning both client transferential patterns and outcome have been presented. However, of major importance here is the fact that the almost undisputed theory that multiple therapy brings about a faster and stronger transference, which in turn results in a more rapid and favorable outcome, is not supported by the findings in this research project.

Another theory that has often been used to explain the greater therapeutic value of multiple therapy can be termed the modeling theory. Many researchers believe that the client's observations of the multiple therapists' relationship with each other can be quite helpful for the client. In this therapeutic environment, the client can observe the model of a presumably healthy relationship between the therapists. Such observations will then supposedly be quite influential in the client learning to have healthier relationships (Kell and Burow, 1970; Dreikurs et al. 1952b). At least two findings in the present study do not lend support to this theory. First, it was found that clients in individual therapy demonstrated greater resolution of problems of an interpersonal nature than clients in multiple therapy. One would expect the exact opposite finding if the modeling factor were a significant variable here. The finding that multiple therapy clients did not develop a

greater capacity to have warm interpersonal relationships than clients in individual therapy was another result that did not support the modeling theory.

One possible explanation for the above findings would be that the multiple therapists' relationships with each other did not generally serve as models of healthy relationships. However, this explanation is doubtful, since Kosch-Graham (1972) found that the present population of multiple therapists seemed to develop a more caring and healthy relationship with each other. By the end of the study, these relationships resembled on some dimensions the type of relationships found among successfully married couples. It is likely then that clients in multiple therapy had the opportunity to observe models of developing and healthy relationships. However, it seems that these observations alone were not enough to produce more favorable therapeutic outcomes for multiple therapy clients.

Another theory that has been presented for explaining the greater effectiveness of multiple therapy can be termed the role-playing theory. Many researchers have suggested that the use of two therapists (rather than one) playing contrived or natural roles can be quite helpful for increasing, dealing with, and clarifying the patient's communications. A variety of rationales have been used for explaining why this technique is effective for dealing with and clarifying patient communications. Dreikurs (1950) believes

that the two therapists' personalities will "automatically" supplement each other, enabling the therapists to deal with more of the patient's communications. Demarest and Teichner (1954) think that if one of the therapists is partially playing the role of participant observer, the two therapists can observe the process from different angles and thus clarify for the patient which reactions are reality based and which are not. Finally, as has been already noted in the discussion on transference (Chapter I), it is believed that the use of two therapists, whom the patient perceives to have different roles, can help the patient produce and deal with a wider range of emotions (Mintz, 1963b; Warkentin et al., 1951).

Besides the general findings of mostly no differences between the two groups on various psychological measures, there were two specific findings here that could be interpreted as being disputations of the role-playing theory. First, it was found that there was no difference between the individual and multiple therapy clients with regard to changes in self-exploration behavior. If the use of two therapists who could play natural or contrived roles was that effective in increasing, dealing with, or clarifying patient communication, we should have found that multiple therapy clients demonstrated greater self-exploration than individual therapy clients. A second result that does not support the role-playing theory was the finding that clients

in multiple therapy did not show any greater increase in their capacity to accept aggression in themselves than did individual therapy clients. If the multiple therapy clients' perceptions of the therapists as having two different roles were beneficial in helping the client to produce and deal with a wider range of emotions, we would have expected clients in multiple therapy (as compared to individual therapy clients) to demonstrate greater increases in their capacity to accept aggression.

Thus, we have found no support in the present study for three major theories that have been used to explain the greater efficacy of multiple therapy. Such lack of support for these theories or for the many other general observations concerning the greater efficacy of multiple therapy, leaves one questioning previous endorsements and praise for the multiple therapy technique. However, any evaluation of the multiple therapy technique can only be considered in the context of the present study, with its own inherent problems and limitations.

Limitations and Their Possible Implications

The findings that were obtained in the present study came from a very specific sample of clients. These clients were all unmarried, female, undergraduate students, with problems of an interpersonal nature. The findings from such a sample only have limited generalizability. The findings

of the present study are also limited in their generalizability, due to the fact that a quite specific sample of therapists was used. All of these therapists were either male or female intern- or staff-level psychologists (at the University Counseling Center), who had either less than two or three to five years of past therapy experience.

There were certain other characteristics of this therapist sample that might be considered as limitations. First, according to Kosch-Graham (1972) only four of the twelve therapists were rated as high functioning on the Carkhuff scales of empathy, respect, genuineness, and concreteness. This lack of high functioning therapists could have adversely affected the outcome data here, since Truax and Carkhuff (1967) have found that high functioning therapists are more likely to have clients with favorable therapeutic outcomes. Another therapist characteristic that might have been limiting was the fact that all of the therapists here had limited general therapy experience and very little experience working in the multiple therapy modality. Finally, none of the therapy pairs had had any previous experience in working together with an individual client. The fact that the therapists here all had limited general therapy experience and very little experience with multiple therapy may have adversely affected the data, since Meltzoff and Kornreich (1970) have found that the level of therapist experience seems to be positively related to favorable client results.

Although Meltzoff and Kornreich were referring to the variable of general level of therapy experience, it seems reasonable to speculate that there may have been more favorable client outcomes in the multiple therapy condition if the therapists here had had more experience with this treatment modality. That the therapists had had no previous experience working together may also have been a limitation, since such researchers as Kell and Burow (1970) emphasize the importance of the two therapists knowing each other, including each other's strengths and limitations, in order for the multiple therapists to be most helpful to the patient.

Another limitation of this study was the fact that the therapy cases here were quite short term in nature. This finding not only limits the generalizability of the study, but may also have adversely affected other findings here. For example, some researchers have found that clients are reluctant or suspicious (Dreikurs et al. 1952a) or anxious and tense (Warkentin et al., 1951) in the first stages of multiple therapy. If multiple therapy clients in the present study were experiencing anxiety or suspicion in the early phases of therapy (see Table 10, Chapter III), it would seem that such feelings could have negatively affected their responses on the TSR, which were given after the first session. A client's subjective ratings either of his progress after the first session in therapy, or of how helping

and understanding his multiple therapists were, might have been biased by anxious or suspicious feelings toward the general therapy situation. It is also possible that if multiple therapy clients experienced such feelings in the beginning of therapy, these feelings might not have completely dissipated during the clients' relatively short stay in therapy. If this were the case, multiple therapy client responses on many posttherapy instruments might have been adversely affected. Although the brief course of therapy here might have been a limitation, it still seems more appropriate to evaluate a therapy case that has ended as a result of mutual termination (as in the present study), rather than evaluating a case after an arbitrary number of sessions have been completed.

There were also other limitations in the present study with regard to the instruments that were used. The instruments that were utilized to measure outcome placed a major emphasis on changes in client self-actualization. Although the author (along with other researchers such as Maslow and Shostrom) believes that such measurements are quite relevant in evaluating therapeutic outcome, others might argue that more commonly used therapy measures (i.e. TAT, MMPI, Rorschach, etc.) would have been more appropriate evaluative tools here. However, it is probable that the additional use of the Problems List, the TSR, the scale of Helpee Self-Exploration, and the measurement of therapy duration

provided this study with adequate criteria for evaluating the efficacy of the two treatment conditions.

Another limitation with regard to the instruments here was the fact that the TSR was only administered after the first and last sessions. Additional administrations might have increased the exactitude of the evaluations, since possible client response bias due to Hathaway's "Hello-Goodbye Effect" or to anxiety or suspicion in the multiple condition would not have had the potential to be as influential in affecting the overall results from the TSR. However, since the number of sessions for each case was not arbitrarily fixed, additional TSR evaluations would probably have necessitated that each client and her therapist(s) fill out a TSR after each session. Such additional administrations might have placed an unfair and perhaps irritating burden on the clients, who had come to the University Counseling Center for therapy, rather than for participation in a research project.

A final limitation of the present study to be discussed was the fact that there was no non-therapy control group. Although this study was designed to compare two types of treatment, a non-therapy control group would certainly have provided us with additional information concerning the general efficacy of multiple and individual therapy. For example, we found on the POI that both individual and multiple therapy clients improved on all six scales of self-actualization. Results from a non-therapy control group would

have determined if these POI changes were the result of treatment or merely due to the time that had passed between pre- and post-instrument administration.

The above limitations must be weighed in any evaluation of multiple therapy that uses data from the present study as evidence contradicting past claims concerning the comparatively greater efficacy of multiple therapy. Due to the fact that some of these limitations may have adversely affected the data, it would seem that further research is indicated before a complete evaluation of multiple therapy can be made.

Areas For Future Research

Due to the fact that so few systematic investigations of multiple therapy have been undertaken, there are many possible areas for future multiple therapy research. One such area is that of therapist variables and their influence upon multiple therapy process and outcome. The effect of such therapist variables as level of previous multiple therapy experience, the amount of time a multiple therapy team has previously worked together, and the sex of the multiple therapy team (heterosexual versus same-sexed teams) definitely merits further examination.

Another area for future research is on the dimension of client variables and their relationship to the effectiveness of multiple therapy. One such variable might be the

presenting problems of the client. Further specification of such problems (as compared to the present study) would be necessary in order to examine more precisely the effect of multiple therapy. For example, the outcome of clients entering therapy with stressful relationships with authority figures (i.e. parents, teachers, employers, etc.) could be compared with the outcome of clients who were experiencing stressful relationships with peers (i.e. boy/girl friend, slightly older or younger sibling, etc.). Data from this study would be helpful in delineating the problem areas where multiple therapy could be most efficacious. Other client variables such as age, sex, and level of education should also be considered in projects concerned with investigating the efficacy of multiple therapy.

Finally, some of the theories that have been presented in the literature to explain the efficacy of multiple therapy (e.g. transference, modeling, etc.) should be more directly studied through the use of scales specifically constructed for the purposes of testing such theories.

When the findings of the present study are considered in conjunction with the fact that multiple therapy is quite expensive both in terms of manpower and financial cost, it would seem almost unethical to continue to treat clients by multiple therapy without simultaneously conducting extensive further investigations into both the efficacy and processes involved in this treatment modality.

APPENDICES

APPENDIX A

SCALES OF THE PERSONAL ORIENTATION INVENTORY[1]

Two Basic Scales:

*TIME COMPETENCE (T_C): Living meaningfully in the present, rather than in the past or the future.

*INNER DIRECTED (I): Independent, self-supportive, rather than dependent and seeking support of others' views.

Ten Subsidiary Scales:

*SELF-ACTUALIZING VALUES (SAV): Affirmation of the primary values of self-actualizing people.

EXISTENTIALITY (Ex): Ability to react situationally or existentially without rigid adherence to principles.

FEELING REACTIVITY (Fr): Sensitivity of response to one's own needs and feelings.

SPONTANEITY (S): Freedom to react spontaneously or to be oneself.

SELF REGARD (Sr): Affirmation of self because of worth or strength.

*SELF ACCEPTANCE (Sa): Affirmation or acceptance of self in spite of weakness or deficiencies.

NATURE OF MAN (Nc): Degree of the constructive view of the nature of man, masculinity, and femininity.

SYNERGY (Sy): Ability to be synergistic, to transcend dichotomies.

*ACCEPTANCE OF AGGRESSION (A): Ability to accept one's natural aggressiveness as opposed to defensiveness, denial, and repression of aggression.

*CAPACITY FOR INTIMATE CONTACT (C): Ability to develop contactful intimate relationships with other human beings, unencumbered by expectations and obligations.

---

[1]From Shostrom (1966b).

*Denotes scales used in the present study.

APPENDIX B

SELF-ACTUALIZATION SCALE (Pre)

NUMBER_____ DATE_____

This questionnaire is being given to you in order to help us understand how you are feeling about certain things.

Indicate your response in the space to the right of each item. Each item should be rated according to the following scale:

0 - if the item is NOT AT ALL descriptive of myself

1 - if the item is a SOMEWHAT ACCURATE description of myself

2 - if the item is a VERY ACCURATE description of myself

****

* 1. I have intense swings in feelings from "high" to "low" _____

2. I have an increased sense of responsibility _____

3. I feel that I know what I have to do to improve myself _____

4. I am able to express hostility _____

5. I have a sense of regard for the welfare and comfort of others _____

* 6. I have a sense of futility and emptiness _____

7. I have ability in general to love _____

8. I have a deep understanding of others _____

9. I have the ability to relax and be myself _____

*10. I find I do daydreaming and introspection which interferes with getting things done _____

*11. Sometimes I feel that I "missed the boat" or somehow have failed to get out of the experience what was potentially there _____

12. I rely on my own values and judgment and am not very dependent on others _____

13. I am anxious _____

*14. I realize I need therapy _____

15. I have good relations with persons I live with _____

16. I am rigid and insistent on having my own way _____

17. I am able to handle hostility and get over it _____

18. I have frequent and persistent feelings of happiness _____

*19. Sometimes I feel depressed _____

20. I am able to make decisions easily _____

21. I am effective in my work and/or school _____

22. I am sensitive to the feelings of others, even when their feelings are not expressed _____

23. I have self-esteem, I have an evaluation of myself _____

24. I am able to communicate with others _____

25. I have a tolerance of others whose opinions, preferences, habits, and attitudes differ from mine _____

26. I have set habit patterns _____

27. I am able to handle various types of situations _____

28. I have an understanding of the importance and meaning of human relationships _____

29. Others' opinions are not very important to me _____

30. I am interested in universal concepts such as meaning of life, my place in relation to social change, etc. _____

---

*Denotes a non self-actualizing item.

APPENDIX C

SELF-ACTUALIZATION SCALE (Post)

NAME:_____ DATE_____

We would like to know how you are feeling about certain things now that you have had some counseling experience.

Indicate your response in the space to the right of each item. Each item should be rated according to the following scale:

0 - if the item is NOT AT ALL descriptive of myself.

1 - if the item is a SOMEWHAT ACCURATE description of myself.

2 - if the item is a VERY ACCURATE description of myself.

Remember the frame of reference (in time) in responding to these items is that of "since" the completion of your counseling experience.

1. A new way of looking at the world _____

* 2. More intense swings in feelings from "high" to "low" _____

3. Increased sense of responsibility _____

4. A feeling that I know what I have to do to improve myself _____

5. More ability to express hostility _____

6. A sense of greater regard for the welfare and comfort of others _____

* 7. A sense of futility and emptiness _____

8. More ability in general to love _____

9. Deeper understanding of others _____

10. More ability to relax and be myself _____

*11. Find I do more daydreaming and introspection which interferes with getting things done _____

*12. A feeling that I "missed the boat" or somehow failed to get out of the experience what was potentially there _____

13. Increased reliance on my own values and judgment, less dependent on others _____

14. Generally decreased anxiety _____

*15. A realization that I need more of this type experience _____

16. Generally improved relations with persons I live with _____

17. I am less rigid and insistent on having my own way _____

*18. Feeling that I wished I hadn't had the counseling experience at all _____

19. More ability to handle hostility and get over it _____

20. More frequent and persistent feelings of happiness _____

*21. More tendency toward feelings of depression _____

*22. A feeling of disappointment in that the counseling experience wasn't what I had hoped it would be _____

23. I find decision-making easier _____

24. Increased effectiveness in my work and/or school _____

25. More sensitivity to the feelings of others, even when their feelings are not expressed _____

26. Increased self-esteem, higher evaluation of myself _____

27. Improved ability to communicate with others _____

28. Greater tolerance of others whose opinions, preferences, habits, and attitudes differ from mine _____

*29. Feeling that the counseling experience was only of temporary benefit to me _____

30. New freedom from old habit patterns _____

31. Feeling increased ability to handle various types of situations _____

32. A greater understanding of the importance and meaning of human relationships _____

33. Relatively decreased importance placed upon others' opinions _____

34. Increased interest in universal concepts such as meaning of life, my place in relation to social change, etc. _____

35. Beneficial changes are noticed by the person closest to me _____

*36. Feeling that the counseling experience was very confusing _____

*37. Feeling that I'm more "messed up" now than ever _____

*Denotes a non self-actualizing item.

APPENDIX D

THERAPY SESSION REPORT[1]

Patient form

This booklet contains a series of questions about the therapy session which you have just completed. These questions have been designed to make the description of your experience in the session simple and quick. There are two types of questions.

One type of question is followed by a series of numbers on the right-hand side of the page. After you read each of the questions, you should circle the number "0" if your answer is "no"; circle the number "1" if your answer is "some"; etc.

The other questions have a series of numbered statements under them. You should read each of these statements and select the one which comes closest to describing your answer to that question. Then circle the number in front of your answer.

Once you have become familiar with the questions through regular use, answering them should only take a few minutes. Please feel free to write additional comments on a page when you want to say things not easily put into the categories provided.

BE SURE TO ANSWER EACH QUESTION

Identification _____

Date of Session _____

[1]From Orlinsky and Howard (1966b).

(P) Form 1

1. HOW DO YOU FEEL ABOUT THE SESSION WHICH YOU HAVE JUST COMPLETED? (Circle the one answer which best applies.)

THIS SESSION WAS
1. Perfect.
2. Excellent.
3. Very Good.
4. Pretty Good.
5. Fair.
6. Pretty Poor.
7. Very Poor.

2. WHAT SUBJECTS DID YOU TALK ABOUT DURING THIS SESSION? (For each subject, circle the answer which best applies.)

DURING THIS SESSION I TALKED ABOUT:	NO	SOME	A LOT
1. RELATIONS WITH OTHERS OF THE SAME SEX.	0	1	2
2. RELATIONS WITH THE OPPOSITE SEX.	0	1	2
3. STRANGE OR UNUSUAL IDEAS AND EXPERIENCES.	0	1	2
4. ATTITUDES OR FEELINGS TOWARD MY THERAPIST.	0	1	2

BE SURE THAT YOU HAVE CHECKED EVERY ITEM

WHAT DID YOU WANT OR HOPE TO GET OUT OF THIS SESSION? (For each item, circle the answer which best applies.)

THIS SESSION I HOPED OR WANTED TO:			
5. GET SOME REASSURANCE ABOUT HOW I'M DOING.	0	1	2
6. GET CONFIDENCE TO TRY NEW THINGS, TO BE A DIFFERENT KIND OF PERSON.	0	1	2
7. FIND OUT WHAT MY FEELINGS REALLY ARE, AND WHAT I REALLY WANT.	0	1	2

(P) Form 2

WHAT PROBLEMS OR FEELINGS WERE YOU CONCERNED ABOUT THIS SESSION? (For each item, circle the answer which best applies.)

DURING THIS SESSION I WAS CONCERNED ABOUT:	NO	SOME	A LOT
8. BEING DEPENDENT UPON OTHERS.	0	1	2
9. BEING LONELY OR ISOLATED.	0	1	2
10. SEXUAL FEELINGS AND EXPERIENCES.	0	1	2
11. EXPRESSING OR EXPOSING MYSELF TO OTHERS.	0	1	2

DURING THIS SESSION, HOW MUCH:	Slightly or not at all	Some	Pretty Much	Very Much
12. DID YOU TALK?	0	1	2	3
13. WERE YOU ABLE TO FOCUS ON WHAT WAS OF REAL CONCERN TO YOU?	0	1	2	3
14. DID YOU TAKE INITIATIVE IN BRINGING UP THE SUBJECTS THAT WERE TALKED ABOUT?	0	1	2	3
15. WERE YOUR EMOTIONS OR FEELINGS STIRRED UP?	0	1	2	3
16. DID YOU TALK ABOUT WHAT YOU WERE FEELING?	0	1	2	3
DURING THIS SESSION, HOW MUCH:				
17. FRIENDLINESS OR RESPECT DID YOU SHOW TOWARDS YOUR THERAPIST?	0	1	2	3

(P) Form 3

	Slightly or not at all	Some	Pretty Much	Very Much
18. WERE YOU ATTENTIVE TO WHAT YOUR THERAPIST WAS TRYING TO GET ACROSS TO YOU?	0	1	2	3
19. WERE YOU NEGATIVE OR CRITICAL TOWARDS YOUR THERAPIST?	0	1	2	3
20. WERE YOU SATISFIED OR PLEASED WITH YOUR OWN BEHAVIOR?	0	1	2	3

21. HOW DID YOU FEEL ABOUT COMING TO THERAPY THIS SESSION?
    1. Eager; could hardly wait to get here.
    2. Very much looking forward to coming.
    3. Somewhat looking forward to coming.
    4. Neutral about coming.
    5. Somewhat reluctant to come.
    6. Unwilling; felt I didn't want to come at all.

22. HOW MUCH PROGRESS DO YOU FEEL YOU MADE IN DEALING WITH YOUR PROBLEMS THIS SESSION?
    1. A great deal of progress.
    2. Considerable progress.
    3. Moderate progress.
    4. Some progress.
    5. Didn't get anywhere this session.
    6. In some ways my problems seem to have gotten worse this session.

23. HOW WELL DO YOU FEEL THAT YOU ARE GETTING ALONG, EMOTIONALLY AND PSYCHOLOGICALLY, AT THIS TIME?

    I AM GETTING ALONG:
    1. Very well; much the way I would like to.
    2. Quite well; no important complaints.
    3. Fairly well; have my ups and downs.
    4. So-so; manage to keep going with some effort.
    5. Fairly poorly; life gets pretty rough for me at times.
    6. Quite poorly; can barely manage to deal with things.

(P) Form 4

24. TO WHAT EXTENT ARE YOU LOOKING FORWARD TO YOUR NEXT SESSION?
    1. Intensely; wish it were much sooner.
    2. Very much; wish it were sooner.
    3. Pretty much; will be pleased when the time comes.
    4. Moderately; it is scheduled and I guess I'll be there.
    5. Very little; I'm not sure I will want to come.

WHAT DO YOU FEEL THAT YOU GOT OUT OF THIS SESSION?
(For each item, circle the answer which best applies.)

I FEEL THAT I GOT:	NO	SOME	A LOT
25. A CHANCE TO LET GO AND GET THINGS OFF MY CHEST.	0	1	2
26. HOPE: A FEELING THAT THINGS CAN WORK OUT FOR ME.	0	1	2
27. HELP IN TALKING ABOUT WHAT WAS REALLY TROUBLING ME.	0	1	2
28. RELIEF FROM TENSIONS OR UNPLEASANT FEELINGS.	0	1	2
29. MORE UNDERSTANDING OF THE REASONS BEHIND MY BEHAVIOR AND FEELINGS.	0	1	2
30. REASSURANCE AND ENCOURAGEMENT ABOUT HOW I'M DOING.	0	1	2
31. CONFIDENCE TO TRY TO DO THINGS DIFFERENTLY.	0	1	2
32. MORE ABILITY TO FEEL MY FEELINGS, TO KNOW WHAT I REALLY WANT.	0	1	2
33. IDEAS FOR BETTER WAYS OF DEALING WITH PEOPLE AND PROBLEMS.	0	1	2
34. MORE OF A PERSON-TO-PERSON RELATIONSHIP WITH MY THERAPIST.	0	1	2
35. BETTER SELF CONTROL OVER MY MOODS AND ACTIONS.	0	1	2

(P) Form 5

WHAT DO YOU FEEL THAT YOU GOT OUT OF THIS SESSION?
(For each item, circle the answer which best applies.)

	NO	SOME	A LOT
36. A MORE REALISTIC EVALUATION OF MY THOUGHTS AND FEELINGS.	0	1	2
37. NOTHING IN PARTICULAR: I FEEL THE SAME AS I DID BEFORE THE SESSION.	0	1	2

38. HOW WELL DID YOUR THERAPIST SEEM TO UNDERSTAND WHAT YOU WERE FEELING AND THINKING THIS SESSION?

MY THERAPIST:
1. Understood exactly how I thought and felt.
2. Understood very well how I thought and felt.
3. Understood pretty well, but there were some things he (she) didn't seem to grasp.
4. Didn't understand too well how I thought and felt.
5. Misunderstood how I thought and felt.

39. HOW HELPFUL DO YOU FEEL YOUR THERAPIST WAS TO YOU THIS SESSION?
1. Completely helpful.
2. Very helpful.
3. Pretty helpful.
4. Somewhat helpful.
5. Slightly helpful.
6. Not at all helpful.

	Slightly or not at all	Some	Pretty much	Very much
40. DID YOUR THERAPIST TALK?	0	1	2	3
41. WAS YOUR THERAPIST ATTENTIVE TO WHAT YOU WERE TRYING TO GET ACROSS?	0	1	2	3
42. WAS YOUR THERAPIST NEGATIVE OR CRITICAL TOWARDS YOU?	0	1	2	3

(P) Form 6	Slightly or not at all	Some	Pretty much	Very much
43. WAS YOUR THERAPIST FRIENDLY AND WARM TOWARDS YOU?	0	1	2	3
44. DID YOUR THERAPIST SHOW FEELINGS?	0	1	2	3

ADDITIONAL COMMENTS:

APPENDIX E

HELPEE SELF-EXPLORATION IN INTERPERSONAL PROCESSES, II

A Scale for Measurement[1]

Level 1

The second person does not discuss personally relevant material, either because he has had no opportunity to do such or because he is actively evading the discussion even when it is introduced by the therapist.

Example: The second person avoids any self-descriptions or direct expression of feelings that would lead him to reveal himself to the therapist.

In summary, for a variety of possible reasons, the second person does not give any evidence of self-exploration.

Level 2

The second person responds with discussion to the introduction of personally relevant material by the first person but does so in a mechanical manner and without the demonstration of emotional feeling.

Example: The second person simply discusses the material without exploring the significance or meaning of the material or attempting further exploration of the feeling in our effort to uncover related feelings or material.

In summary, the second person responds mechanically and remotely to the introduction of personally relevant material by the first person.

Level 3

The second person voluntarily introduces discussions of personally relevant material but does so in a mechanical manner and without the demonstration of emotional feeling.

Example: The emotional remoteness and mechanical manner of the discussion give the discussion a quality of being rehearsed.

---

[1]From Carkhuff (1969).

In summary, the second person introduces personally relevant material but does so without spontaneity or emotional proximity and without an inward probing to newly discover feelings and experiences.

Level 4

The second person voluntarily introduces discussions of personally relevant material with both spontaneity and emotional proximity.

Example: The voice quality and other characteristics of the second person are very much "with" the feelings and other personal materials which are being verbalized.

In summary, the second person introduces personally relevant discussions with spontaneity and emotional proximity but without a distinct tendency toward inward probing to newly discover feelings and experiences.

Level 5

The second person actively and spontaneously engages in an inward probing to newly discover feelings and experiences about himself and his world.

Example: The second person is searching to discover new feelings concerning himself and his world even though at the moment he may be doing so, perhaps, fearfully and tentatively.

In summary, the second person is fully and actively focusing upon himself and exploring himself and his world.

APPENDIX F

DIRECTIONS FOR RATING PROBLEMS LIST

First, please read the client's pretherapy problems list. Secondly, read the client's posttherapy problems list. Then rate the client's perceived degree of change (on the posttherapy problems form) generally over all problems. Please use the following scale to rate your general impression of the client's stated degree of change, not your own impression of how much the client changed. You need not use all of the scores on the scale.

A Lot Worse	A little Worse	No Change	A Little Improvement	A Lot of Improvement
-2	-1	0	+1	+2

APPENDIX G

PROBLEMS LIST (Pre)

Number _____ Date _____

Please list and briefly describe three major problems concerning you and other people that are bothering you at the present time.

1.

2.

3.

4.

APPENDIX H

PROBLEMS LIST (Post)

Number _____ Date _____

Before starting counseling, you described three major problems concerning you and other people that were bothering you. Would you please describe what, if any, changes have resulted from your counseling experience in regard to these problems.

1.

2.

3.

4.

APPENDIX I

CLIENT'S INFORMATION AND CONSENT FORM

During this quarter a research project on counseling is being conducted at the Counseling Center. We are asking you students to participate in this research. Your participation will involve filling out some questionnaires and having your counseling sessions recorded. The questionnaires will require two hours before your first counseling session, two hours at the end of the quarter, and a few minutes after three of the sessions.

The research will not influence the counseling you receive in any way and your counselor(s) will not see any of the information.

We hope that the knowledge obtained from this research will enable counselors to help future clients more effectively.

In order to keep these records confidential, you will be assigned a number which will be the only identifying mark used on all the forms and the tape labels.

We would appreciate your signature at the bottom of this form, giving your consent to be part of this study.

If you do not want to participate, simply return this form to the secretary unsigned. Your refusal also will not alter the service you are to obtain.

Thank you very much.

_____ _____

Signature Date

APPENDIX J

NUMERICAL RAW DATA AND SUMMARIES

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #1		Item #2_{1-4}		Item #2_2		Item #2_4		Item #17	
Individual Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
7	5	5	3	3	2	2	0	0	2	2
12	4	6	2	4	1	1	0	1	2	2
17	4	3	4	3	2	2	1	1	2	2
21	4	3	3	1	1	0	1	0	2	2
22	4	5	4	4	1	1	1	1	2	2
23	3	5	2	1	0	2	1	0	1	2
29	4	5	1	1	2	0	0	1	1	3
30	6	6	2	3	2	0	0	1	3	3
34	4	6	4	3	1	1	2	4	2	3
38	4	3	4	4	2	1	1	1	2	2
39	4	5	4	3	1	1	1	1	3	3
40	4	5	3	2	1	1	1	0	1	3

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #19		Item #22		Item #23		Item #24	
Individual Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
7	0	0	5	5	4	5	4	5
12	0	0	4	4	3	6	4	4
17	0	1	5	5	2	4	2	5
21	0	0	4	3	3	3	4	4
22	0	0	2	5	3	5	4	4
23	0	1	4	5	2	2	5	6
29	0	0	2	3	3	5	4	5
30	0	0	4	5	5	4	4	5
34	0	1	5	2	5	4	6	4
38	0	0	5	2	3	4	4	4
39	1	0	1	2	3	6	4	5
40	0	0	1	5	4	4	4	6

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #26		Item #27		Item #28		Item #29		Item #30	
Individual Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
7	1	2	1	1	2	2	1	2	2	1
12	1	1	0	2	0	2	1	2	1	2
17	1	2	0	1	1	1	0	1	0	0
21	1	0	2	1	2	0	0	0	2	0
22	1	2	1	1	2	2	0	1	0	1
23	0	0	0	0	1	1	0	0	1	2
29	1	2	2	0	2	2	0	0	1	0
30	1	2	2	2	2	0	1	2	1	2
34	0	2	1	2	1	2	0	2	0	2
38	2	2	1	1	1	2	2	1	1	1
39	2	2	1	2	2	2	1	1	1	2
40	1	2	1	2	1	2	0	0	1	0

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #31		Item #32		Item #33		Item #34		Item #35	
Individual Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
7	1	1	1	2	0	1	2	1	1	1
12	0	1	0	1	1	2	1	1	1	1
17	0	0	0	0	1	0	0	2	1	1
21	0	1	2	1	1	1	2	1	1	0
22	1	1	1	1	1	1	0	0	1	2
23	0	0	0	0	0	0	0	0	1	0
29	1	1	1	0	0	1	0	0	1	1
30	2	2	1	1	1	2	1	2	2	1
34	1	1	1	1	1	2	0	2	1	2
38	1	1	1	1	1	2	1	1	0	1
39	0	1	0	1	1	2	1	1	0	2
40	0	2	1	2	0	1	0	1	1	2

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

Individual Therapy Client	Item #36		Item #37		Item #38		Total After First Session Score Items 26-38	Total Post Therapy Score Items 26-38
	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy		
7	2	2	1	2	0	0	15	18
12	0	2	0	2	0	0	6	19
17	0	0	0	1	1	0	6	8
21	1	0	1	1	0	2	15	8
22	1	0	1	1	1	0	11	11
23	0	0	1	2	0	0	4	5
29	0	0	1	1	0	0	10	8
30	1	2	1	2	0	0	16	20
34	0	1	1	2	0	0	7	21
38	1	1	2	2	0	0	14	16
39	1	1	2	2	0	0	12	19
40	0	2	0	1	0	0	6	17

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

Multiple Therapy Client	Item #36		Item #37		Item #38		Total After First Session Score Items 26-38	Total Post Therapy Score Items 26-38
	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy		
8	0	0	1	1	2	1	7	7
10	1	2	2	2	1	0	19	24
14	0	1	2	1	1	1	12	19
16	0	2	1	1	0	0	10	19
20	0	0	2	1	0	1	13	7
25	0	2	1	2	0	0	5	20
26	0	0	1	0	2	1	10	8
31	0	1	1	2	0	0	13	22
33	1	1	2	1	0	0	22	17
35	0	0	1	1	1	1	9	8
36	0	1	0	2	0	0	6	20
37	1	1	1	2	0	0	16	20

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #39		Item #40		Item #43		Item #44	
Individual Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
7	4	4	5	4	0	0	2	2
12	4	4	4	5	0	0	2	2
17	3	3	2	4	0	0	2	1
21	3	2	4	2	1	1	1	1
22	4	4	4	5	0	0	2	3
23	4	4	4	3	0	1	1	0
29	4	5	5	6	0	0	3	3
30	4	4	6	6	0	0	3	3
34	3	4	3	5	0	0	2	3
38	4	4	5	4	1	0	1	2
39	3	3	4	5	1	0	1	2
40	3	4	4	5	0	0	3	3

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #1		Item #2_{1-4}		Item #2_2		Item #2_4		Item #17	
Multiple Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
8	5	5	3	2	1	0	1	1	3	2
10	4	6	4	3	2	2	1	0	3	3
14	4	4	3	2	1	2	1	0	2	3
16	3	5	2	2	1	2	1	1	1	2
20	6	3	2	2	2	2	0	2	2	2
25	4	6	2	4	1	2	0	1	2	3
26	4	2	2	3	2	1	0	1	2	1
31	5	6	2	4	0	1	0	1	3	3
33	5	5	4	1	1	2	1	0	3	2
35	3	2	3	3	1	1	1	1	2	1
36	3	5	3	3	1	2	1	1	2	2
37	5	4	4	4	1	1	1	1	2	2

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

Multiple Therapy Client	Item #19		Item #22		Item #23		Item #24	
	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
8	0	0	3	4	3	4	4	3
10	0	0	5	6	3	5	4	5
14	1	0	4	4	3	4	4	4
16	1	3	3	4	4	6	4	4
20	0	1	5	2	6	2	4	4
25	0	0	5	5	3	5	2	5
26	1	2	4	2	3	2	2	2
31	0	1	4	5	4	5	5	5
33	0	0	2	5	5	5	2	4
35	1	2	2	3	2	2	4	4
36	0	0	2	4	1	6	3	5
37	0	0	4	2	3	5	2	4

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #26		Item #27		Item #28		Item #29		Item #30	
Multiple Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
8	1	0	0	0	1	1	0	0	0	1
10	1	2	2	2	2	2	1	2	2	2
14	2	2	1	1	1	2	2	2	2	2
16	1	1	1	2	1	1	1	2	0	2
20	1	2	1	0	2	1	1	1	1	0
25	1	2	1	2	1	2	0	2	0	2
26	2	1	0	0	1	0	1	1	2	1
31	1	2	1	2	2	2	2	2	2	2
33	1	2	2	2	2	2	2	2	2	2
35	2	1	1	1	1	0	0	0	1	1
36	2	2	0	2	1	2	1	2	0	1
37	1	2	2	2	2	2	1	2	2	2

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item # 31		Item #32		Item #33		Item #34		Item #35	
Multiple Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
8	0	0	0	0	0	1	0	0	2	2
10	1	2	2	2	1	2	2	2	1	2
14	0	2	0	1	0	2	0	1	1	1
16	2	1	1	1	0	2	1	2	1	2
20	1	0	1	0	1	1	1	0	1	0
25	1	1	0	0	0	2	0	1	0	2
26	0	1	0	1	0	1	0	1	1	0
31	1	2	1	1	1	2	0	2	1	2
33	2	1	2	1	2	1	2	1	2	1
35	1	0	0	0	0	1	0	1	1	1
36	1	2	0	1	0	2	0	2	1	1
37	1	1	1	2	1	1	1	2	2	2

TABLE 25

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POSTTHERAPY RESPONSES TO THE TSR ITEMS

	Item #39		Item #40		Item #43		Item #44	
Multiple Therapy Client	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy	After First Session	Post Therapy
8	3	2	2	4	0	1	3	1
10	3	4	4	6	0	1	2	3
14	3	3	3	4	1	0	2	2
16	3	4	3	6	1	1	2	2
20	4	3	6	2	1	1	2	2
25	4	5	3	5	1	1	2	3
26	3	2	3	2	1	1	1	0
31	4	5	5	6	0	1	3	3
33	4	4	5	5	0	0	3	3
35	3	3	2	2	1	1	1	1
36	3	4	4	5	0	1	1	2
37	4	3	4	5	0	0	3	3

TABLE 26

PRE AND POST THERAPY SCORES OF THE MULTIPLE AND INDIVIDUAL THERAPY CLIENTS ON SIX POI SCALES[1]

Individual Therapy Client	T_C		I		SAV		Sa		A		C	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
7	16	18	93	100	21	25	17	17	20	20	20	22
12	16	20	89	101	19	20	17	18	13	21	20	24
17	10	10	62	69	18	22	9	9	13	17	14	15
21	11	11	62	62	21	21	9	9	11	11	13	13
22	14	13	88	79	24	17	17	15	18	18	18	20
23	17	19	78	91	19	20	13	17	18	22	15	18
29	11	9	83	85	21	24	10	12	20	20	21	18
30	16	21	96	97	23	19	15	16	15	16	19	24
34	15	21	80	105	22	25	14	19	15	21	16	25
39	11	9	55	61	10	14	10	10	14	14	12	13
40	11	15	64	70	14	17	16	17	9	10	11	12

[1]As was explained in Chapter II, Individual Therapy Client #38 and Multiple Therapy Client #35 were dropped from the sample for the data analyzation of the POI scales.

TABLE 26

PRE AND POST THERAPY SCORES OF THE MULTIPLE AND INDIVIDUAL THERAPY CLIENTS ON SIX POI SCALES[1]

Multiple Therapy Client	T_C		I		SAV		Sa		A		C	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
8	16	16	77	82	18	18	15	16	13	14	16	10
10	15	19	77	96	15	18	14	17	17	19	18	25
14	9	10	83	83	21	21	17	16	17	16	18	18
16	14	15	75	95	21	20	16	19	16	18	13	19
20	18	17	77	82	19	18	13	16	14	17	17	17
25	12	21	82	99	19	22	14	17	19	19	15	21
26	9	12	54	56	8	11	11	15	8	6	11	10
31	18	19	103	112	22	25	20	22	21	20	23	26
33	16	18	74	95	15	17	16	23	15	17	15	22
36	11	14	77	76	20	23	8	12	15	16	18	15
37	10	18	72	89	16	19	11	14	16	21	13	18

[1]As was explained in Chapter II, Individual Therapy Client #38 and Multiple Therapy Client #35 were dropped from the sample for the data analyzation of the POI scales.

TABLE 27

MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' AFTER FIRST SESSION AND POST THERAPY AVERAGE RATINGS ON THE CARKHUFF SCALE OF SELF-EXPLORATION

Individual Therapy Client	After First Session	Post Therapy	Multiple Therapy Client	After First Session	Post Therapy
7	2.8333	2.5000	8	2.4167	2.4167
12	3.0833	3.3333	10	2.9167	2.4167
17	2.5833	3.0833	14	2.8333	2.5833
21	2.0833	2.5000	16	2.7500	2.6250[a]
22	3.5833	3.5833	20	3.1667	3.0000
23	2.4167	3.1667	25	3.3333	2.6667
29	3.9167	3.0000	26	1.9167	2.3333
30	2.5833	2.6667	31	3.0000	3.4167
34	3.3333	3.9167	33	3.0000	1.7500
38	3.0833	3.0000	35	2.3333	2.6667
39	3.0833	2.9167	36	3.2500	2.9167
40	2.4167	2.5833	37	2.7500	2.5000

Note: Except as noted, all of the average ratings are based on the two judges' ratings of three 5-minute segments.

[a]The average rating of the two judges on two 5-minute segments.

TABLE 28

JUDGES' RATINGS OF MULTIPLE AND INDIVIDUAL THERAPY CLIENTS' RESPONSES TO THE PROBLEMS LIST

Individual Therapy Client	Judge #1	Judge #2	Judge #3	Mean Rating
7	4	4	4	4.0000
12	5	5	5	5.0000
17	5	5	5	5.0000
21	4	4	4	4.0000
22	5	5	5	5.0000
23	5	4	5	4.6667
29	5	4	4	4.3333
30	5	4	5	4.6667
34	5	5	5	5.0000
38	4	4	4	4.0000
39	5	4	5	4.6667
40	5	5	5	5.0000
Multiple Therapy Client				
8	4	4	4	4.0000
10	4	3	4	3.6667
14	4	4	4	4.0000
16	5	5	5	5.0000
20	3	3	3	3.0000
25	5	5	5	5.0000
26	3	2	2	2.3333
31	5	5	5	5.0000
33	4	4	4	4.0000
35	2	1	3	2.0000
36	5	5	5	5.0000
37	5	4	5	4.6667

TABLE 29

CLIENTS' SCORES ON THE SELF-ACTUALIZATION SCALE (POST) IN MULTIPLE AND INDIVIDUAL THERAPY CONDITIONS

Individual Therapy Client	Self-Actualizing Items Question Number																										Sub Score I
	1	3	4	5	6	8	9	10	13	14	16	17	19	20	23	24	25	26	27	28	30	31	32	33	34	35	
7	1	1	2	0	1	1	1	2	2	1	1	1	0	1	2	2	1	2	1	1	2	2	2	0	1	2	33
12	2	2	2	1	1	1	1	1	2	2	2	1	1	2	2	2	1	2	2	1	2	2	2	2	1	2	42
17	1	1	1	2	1	1	2	1	2	1	1	0	1	1	0	0	1	1	2	1	1	1	1	1	2	2	29
21	1	1	2	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	2	2	0	1	2	1	1	0	27
22	1	1	1	0	1	1	1	1	1	1	1	1	0	1	0	1	1	1	1	1	1	1	2	1	1	1	24
23	0	0	0	0	0	1	1	0	0	2	1	0	0	2	0	2	1	0	0	0	0	0	0	0	0	0	10
29	1	0	2	1	0	0	1	0	1	1	0	0	1	2	0	0	1	2	1	1	1	0	1	0	0	0	17
30	1	0	1	1	0	1	2	1	1	1	0	1	1	1	0	1	2	1	1	0	1	1	2	0	0	1	22
34	2	0	1	1	1	2	2	2	2	2	1	1	1	2	2	1	2	2	2	2	2	2	2	1	2	2	42
38	1	1	1	2	1	1	2	1	2	2	2	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	32
39	2	1	1	1	1	0	1	1	2	1	0	0	1	1	1	2	2	1	0	0	1	1	2	2	2	2	28
40	2	2	2	2	0	0	1	2	2	2	0	0	2	2	2	1	0	2	0	0	2	2	0	0	0	1	29

TABLE 29

CLIENTS' SCORES ON THE SELF-ACTUALIZATION SCALE (POST) IN MULTIPLE AND INDIVIDUAL THERAPY CONDITIONS

Individual Therapy Client	Non Self-Actualizing Items Question Number											Sub Score II	Total Score Subscore I + Subscore II
	2	7	11	12	15	18	21	22	29	36	37		
7	2	2	2	2	2	2	2	2	2	2	2	22	55
12	2	2	2	2	1	2	2	2	2	2	2	21	63
17	2	1	1	2	1	2	1	2	1	1	2	16	45
21	2	2	2	1	2	2	2	1	1	1	2	18	45
22	2	2	1	2	0	2	2	2	2	2	2	19	43
23	2	2	2	2	2	2	2	0	2	2	2	20	30
29	2	2	2	2	2	2	2	1	2	2	2	21	38
30	2	2	2	2	1	2	2	2	2	2	2	21	43
34	1	2	2	2	1	2	2	2	2	2	2	20	63
38	2	2	2	2	0	2	2	2	2	1	2	17	49
39	1	1	1	2	0	2	1	2	2	2	2	16	44
40	1	2	2	2	2	0	2	0	2	2	2	17	46

TABLE 29

CLIENTS' SCORES ON THE SELF-ACTUALIZATION SCALE (POST) IN MULTIPLE AND INDIVIDUAL THERAPY CONDITIONS

Multiple Therapy Client	Self-Actualizing Items — Question Number																										Sub Score I
	1	3	4	5	6	8	9	10	13	14	16	17	19	20	23	24	25	26	27	28	30	31	32	33	34	35	
8	0	0	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	4
10	1	1	1	2	1	1	1	2	2	1	2	2	2	1	1	1	1	2	2	2	2	2	2	2	1	0	38
14	2	0	2	0	0	1	1	2	2	1	0	1	0	1	1	1	1	1	1	1	1	1	2	1	1	0	25
16	1	2	2	2	0	1	2	2	2	2	2	0	2	1	0	0	1	2	1	1	2	2	1	2	1	2	36
20	1	2	1	1	0	0	1	1	1	0	0	0	1	1	1	0	0	0	0	0	0	1	0	1	0	1	14
25	1	2	2	0	0	0	1	1	2	1	2	1	0	1	2	2	0	2	2	2	2	2	2	1	1	2	34
26	0	1	0	2	0	0	0	0	1	0	1	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	8
31	2	1	2	1	1	1	1	2	2	2	2	1	1	2	2	2	2	2	2	1	2	2	2	1	2	1	43
33	1	1	2	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	0	1	1	25
35	0	1	1	0	1	1	1	0	1	0	0	1	1	0	0	0	1	0	1	1	0	1	1	1	0	0	14
36	1	0	2	1	0	0	0	1	1	1	2	0	1	2	0	0	0	2	1	0	0	1	1	2	0	0	19
37	1	1	2	1	2	1	2	2	1	1	2	2	1	2	1	0	2	2	2	2	2	2	2	2	1	0	39

TABLE 29

CLIENTS' SCORES ON THE SELF-ACTUALIZATION SCALE (POST) IN MULTIPLE AND INDIVIDUAL THERAPY CONDITIONS

Multiple Therapy Client	Non Self-Actualizing Items: Question Number											Sub Score II	Total Score Subscore I + Subscore II
	2	7	11	12	15	18	21	22	29	36	37		
8	1	1	1	0	1	2	1	1	2	1	2	13	17
10	2	2	2	2	1	2	2	2	2	2	2	21	59
14	1	2	2	2	1	2	2	2	2	2	2	20	45
16	2	2	2	2	1	2	2	2	2	2	2	21	57
20	2	2	2	0	2	2	2	1	2	0	2	17	31
25	2	2	2	2	0	2	2	2	2	1	2	19	53
26	2	0	0	1	1	1	1	0	1	1	1	9	17
31	2	2	2	2	0	2	2	2	2	2	2	20	63
33	2	2	2	2	1	2	2	2	2	2	2	21	46
35	1	1	2	0	2	1	1	0	2	0	1	11	25
36	2	2	2	2	0	2	2	2	2	2	2	20	39
37	2	2	0	1	2	1	2	2	1	1	1	16	45

TABLE 30

NUMBER OF SESSIONS UNTIL TERMINATION FOR CLIENTS IN THE MULTIPLE AND INDIVIDUAL THERAPY CONDITIONS

Individual Therapy Client	Number of Sessions	Multiple Therapy Client	Number of Sessions
7	5	8	6
12	22	10	6
17	5	14	5
21	4	16	9
22	15	20	7
23	4	25	9
29	5	26	4
30	9	31	15
34	7	33	12
38	5	35	7
39	10	36	6
40	4	37	4

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BIOGRAPHICAL SKETCH

Charles Alan Reiner was born October 13, 1946, in New York City. He graduated from Great Neck North Senior High School in Great Neck, New York, in June, 1964. He received his Bachelor of Science degree in June, 1968, from the University of Pittsburgh in Pittsburgh, Pennsylvania. In September of 1968, he entered the Department of Psychology of the University of Florida. From 1968 to 1969, he had a U.S.P.H.S. Traineeship, while from 1969 to 1970, Mr. Reiner held a departmental teaching assistantship. In June of 1970, he was awarded a Master of Arts degree. From 1970 to 1971, he was a Level II Trainee at the V.A. Hospital in Gainesville, Florida. In September of 1971, Mr. Reiner began a twelve-month internship at the New York State Psychiatric Institute of Columbia University.

Charles Alan Reiner is married to the former Gail Toni Davis. The couple have one daughter, Alysia Michelle, who was born in July of 1970.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Harry A. Grater, Jr., Chairman
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Hugh C. Davis
Professor of Psychology

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Madeline M. Ramey
Assistant Professor of Psychology

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Vernon Van de Riet
Associate Professor of Psychology

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Thomas L. Hanna
Professor of Philosophy

June, 1973

This dissertation was submitted to the Department of Psychology in the College of Arts and Sciences and to the Graduate Council, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

Dean, Graduate School